			State of Maryland / Department of	•	
			1- State Registrar Certificate	of Death	Reg. No. UUD UIUUI
	Physici	an	Decedent's Name (First, Middle, Last)	Mon	
1	/Medi	cal	Melvin Oliver Wilson 4a. Facility Name (If not institution, give street and number) 4b. City, Tov	m, or Location of Death	02 05 12:26 PM
1	Examir	ner	111 - 11 - 1	mberland	Allegany
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y		of Birth 9. Birthplace (State or Foreign Country)
	Director		213-12-9207 83 Yrs.		Jan-1921 Maryland
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Mary a-f sh	tor	Maryland Allegany Frostburg		1 Yes 2 □ No
	or 28	Director	10e. Street and Number 11002 Welsh Hill Road, S.W.	de	10g. Citizen of What Country?
	s 23a	eral	21532 11. Marital Status		U.S.A. s or No- 14. Race - American Indian,
(0	r item	Funeral	1 Never Married 2 Married 1 MYes 2 No	of Hispanic Origin? (Specify Yes Cuban, Mexican, Puerto Rican, e	tc.) Black, White, etc.
21215-0036	within 72 hours after death with the Maryland ene. than "naturat", or items 23a or 28a-1 show he Medical Evantrat must be notified at	d by	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates: WW II 1 □ Yes 2 □	No Specify:	Specify: White
15-("natu	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work of life DO NOT use of	ccupation one during most of working etired)	16b. Kind of Business/Industry
212	filed with! Hygiene. ther then nt, the M	omp	Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) Iaborer		pasta manufacturer
nd	be filed within 72 hours after death with the Marylan ital Hygiene. d other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show ent, the Medical Exaction of the motified at	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, I	Middle, Maiden Sumame)
Maryland		70	John W. Wilson	Bessie Dohn	
Mar	12 s 7 is treu		19a. Informant's Name/Relationship (Type, Print) Mary E. Wilson 19b. Mailing Address (St. 11002 Welsh Hill I		Number, City or Town, State, Zip Code)
	Hee Hee		20a. Method of Disposition 20b. Place of Disposition (Name	of Date	Maryland 21532- 20c. Location - City or Town, State
E C	0 0 = =		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Frostburg Memorial Park		005 Frostburg Maryland
Baltimore,	permit. Pag Depertment Importent: I any injury o		21. Signature of Funeral Service Licensee 22. Name and A	ddress of Facility	
ш	40 E # 9		Durst Funer 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of		ve., Frostburg, MD 21532
			shock, or heart failure. List only one cause on each line.		Interval Between
1	Enysician /Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	Conte den	11/2 m 2/1/500
	Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, b.	ARTTERY DU	SEASIE
	ed str	Examiner	Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury		
,	be executed siclen and burial-transit	Exan	that initiated events resulting in death) Last		
8760,	9 2 0	icai	d		
9	eath certifical ettending phy I for use as th	Physician/Med	IF FEMALE:		
Вох	eath c ettenc for us	cian	23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (specific forms)		23d. Date of delivery Month Day Year
P.O.	that the de sed by the e detached i	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		
	res tha igned I be det	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	a given in Part I. 23e	e. Did tobacco use contribute to the cause of death?
ord	v requir been si should	sted	PULMOTARY COBPUSIS		1 Yes 2 No 3 Probably 4 Unknown
Records,	ne law hest ge 2 s	Completed			a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
tal	(Q 400	e Co	CUANNE OBSTAUTIVE LUNG DIGE. 25. Was case referred to medical	26. Place of Death (Check	Yes 2 No 1 Yes 2 No
ί	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other	Residence 6 Other (Specify)
Division of Vital	ing Ph liter th uneral			Wark?	scribe how injury occurred
isio	Attending in death. sector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, of	1 Yes 2 No	ation (Street and Number or Rural Route Number,
Σį	p di ji	Certification:	4 Homicide determined building, etc. (Specify)		r or Town, State)
	e Hospitel 24 hours a e Funerei letely filled	edicai (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at to (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in	ne time, date and place, and due	to the cause(s) and manner as stated.
	To the h within 24 To the F complete	Medi	one) and manner stated.	cense number	29d. Date signed (Month, Day, Year)
	-1			6907	
	BIIVA		30 Name and address of passen who completed equal of death (from 33a) (Type Print)		JANUARY 3, 2005
	nas		DR. Harrit SIDHU 925 BIShop Walsh R	oad, cumberla	ind, MD 21508
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 4 2005 32. Registrar's Signature		
	negisti	ui	JAN U 4 ZUUD Salar Co Sporter		

DHMH 17 Rev 1/2001

ORIGINAL

Zachary Allan Winters 05-00025 RPD

or Print in Black Indelible Ink. Ensure All Copies Are Legible.

000	•	1	For State Registrar	state of Maryland / Dep Ce	artment of Hertificate of L	ealth and M Death	Re	g. No.	0 1 0 0 2
	Physicia	_	No (Cimb Middle Leet)	achary Allan Winters			2. Date of Death January	1, 2005 ear	0500 P M
	/Medica	4:	a. Facility Name (If not institution, give stre 3814 Marshall Porte	et and number) er Road	4b. City, Town, or LaVale	Location of Death		4c. County of Deat Allegany	
	Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. last birthday 20 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 24, 1	Year) Co	hplace (State or Foreign Juntry) Maryland
		. 1	Jsual Residence of Decedent Oa. State 10b. County Maryland Allegan	10c. City, Town or t	Location	LaVale			10d. Inside City Limits 1 ☐ Yes 2 💆 No
with the Ma	s or 28e-f	Directo	10e. Street and Number 13814 Marshall	Porter Road	10f. Zip Code	21502	10	0g. Citizen of What Co US	
1 2 13-0030	s I and 2 Should be little within 12 hours and 23s or 28s-f show the little and Mental Hypithes. I Health and Mental Hypithen. Instructly, or Items 23s or 28s-f show title m 27 is marked other than "naturely, or Items 23s or 28s-f show other treumstic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:		14. Race - Ame Black, White Specify:	White
0000-0171	ne. han "naturel	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion (Gineral Lands) College (1-4or 5+)	cedent's Usual Occup ive kind of work done b. DO NOT use retired M	lechanic	king		ndustry
V	lid be illed lental Hygie rked other i lic event, it	Be	17. Father's Name (First, Middle, Last)	Robert Winters				i McKenzie	
lary	thand Menith and Menithe and Menith and Menithe and Menith and Menithe and Menith and Me	ပ	19a. Informant's Name/Relationship (<i>Type</i> Lora Shircliffe-M	lother	11903	and Number or Ru Sage Avenue	e, Cumberland	d, Maryland 2150)2
	ages 1 and ent of Health at: If Item 27 by or other ti		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, c	sposition (Name of crematory or other plates of losephs Cemeter	у	Date anuary 05, 2005	20c. Location - City o Midland,	Maryland
Baltii	permit. Pages I Department of H Important: If Ite any injury or ot		21. Signature of Funeral Service Licenses			enzie Funeral I			oning, Md. 21539
	Physician /Medical Examiner		23a. Party. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the death. Do not a cause on each line. The transval Due to (or as a consequence of):	enter the mode of dyi	ng, such as cardiac	c or respiratory an	rest,	Approximate Interval Between Onset and Death
,09	be executed Sicien and burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):					
). Box 68	ie death certificate I the attending physi hed for use as the I	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	ac. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of o Month	delivery Day Year
ls, P.O.	w requires that the de s been signed by the should be detached	by	Part II. Other significant conditions con	tributing to death but not resulting in th	he underlying cause g	liven in Part I.	23e. Did t	M	to the cause of death? Probably 4 Dinknown
of Vital Records,	e la has	Completed					24a. Was auto perfo		
tall	icien: Th certificate rector, pag	a)	25. Was case referred to medical				eath (Check only		
Į.	Physicien: r this certific ral director,	To B	1 X Yes 2 No		batient 3 DOA		28d Describe	how injury occurred	pecify) At Scene
ion o	ttending Pr death. ctor: After th y the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury 1-1-05 Found	Ury SECOPM 1	Yes 211 No		Shot hir	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral of the funeral	Certification:	3 🕱 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fam building, etc. (Specify)	At home		Rd L	avale m	
	Hospit 24 hours Funere	edical (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my knowledge, iner: On the basis of examination and and manner stated.	death occurred at the for investigation, in m	time, date and pla y opinion, death oc	ce, and due to the curred at the time,		
	To the To the comple	Me	29b. Signature and title of certifier	in D		M.E.		January 2,	
	2		30. Name and address of person who co	ompleted cause of death (Item 23a)	Type, Print) 1 Penn Str	eet, Bal	timore,	Maryland 2	1201
	//		31 Date filed (Month, Day, Year)	32. Registrar's Signature					

Registrar

JAN 0 5 2005 Alected to Aparle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 6.34 PM **Physician** 2005 Alston-West Patricia anvaru Ann edical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Maryland General Haspita 5. Social Security Number 6. Sex 7. Ace Baltimoro Cita If Under 1 Year | If Under 24) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 08 15 Age (In yrs. last birthday) Days **Funeral** 1 □ M **X**(XF NC Director 241-02-5582 33 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1X Yes 2 □ No Director NA Baltimore MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21217 U.S.A. Street 2016 Division death v Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 end 2 should be filed within nent of Heelth and Mental Hygiene. int: if item 27 is marked other than ' Flementary/Secondary (0-12) College (1-4or 5+) Private Duty Nursing Tech. 10th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patricia Mann Lee Alston Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2016 Division Street, Baltimore, Md 21217
of Disposition (Name of Date 20c. Location - City or Town, State Michael West-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Murial 2 Cremation 3 Removal from State permit. Page Department o Important: If any Injury or King Memorial Park 1/22/05 Randallstown, Md 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of Facility 21215 Approximate Baltimore, Md Interval Between Onset and Death Immediate Cause (Final Priysician Aspration disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Use to (or as Insequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner c. End Stage Human Immunodeficiency Virus signed by the attending physicien and a be detached for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, 3 ☐ Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 1 Yes certificate or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ ctor: After this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending ours after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital

within 24 hours a

To the Funeral C

completely filled

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certific

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

6 Could not be determined

0/0 M.D.

MAULK BHALANEMS

maryland General

1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

89523

Haspital

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)
JAN 1 9 2005

32. #egistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			State of Maryland / Department of Health and M Amend Item 19b per fh G839 1-19-05 Certificate of Death	fental Hygi	ene g. No. 2005	01004
	Physicia		Decedent's Neme (First, Middle, Last) RUTH C • ARNOLD	2. Dete of Deeth Month	Day Year	3. Time of Death
	/Medic Examin	al -	4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Lo	cation of Death	4c. County of Deeth	Q. 3311
1	Examin	e:	Lorien at Bel Air Bel Air		Harrford	
	Funeral Director		5. Social Security Number 218-32-8820 6. Sex 1 Months 7. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 9. Age	8. Date of Birth (Month, Dey, 5/18/19		place (State or Foreign http) 71and
	pue M.	-	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
	Menyl	to	MD Harford Street			1 ☐ Yes 🌠 No
	th with the Merylen 23e or 28e-f show ust be notified at	ai Director	10e. Street end Number 806 Coen Road 10f. Zip Code 21154	10	og. Citizen of What Cour USA	ntry?
020	filed within 72 hours after deeth with the Meryland Hygiene. ther than "naturel", or thems 23e or 28e-f show ent, the Medical Examinet must be institled at	by Fur	11. Maritel Status 1 □ Never Merried 2 □ Married 1 □ Never Merried 2 □ Married 1 □ Never Merried 2 □ Married 1 □ Yes 2 ▼ No 1 □ Yes 2 ▼	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
Baltimore, Maryland 21215-0020	within 72 ho iene. than "natur na Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Homemaker	ing	66b. Kind of Business/In	,
land 2	should be filled withing and Mental Hygiene. Branked other than a marked other than wmatic event, the Mental than	o Be Co	17. Fether's Name (First, Middle, Last) John Holmes 18. Mother's Name Clara	16	faiden Sumame) ncan	
Aary			19a. Informant's Name/Relationship (Type, Print) Martin W. Amold/Scn 19b. Mailing Address (Street and Number or Run 1200 Winterstown Road 1200 Function (Scn)	al Route Number, L. Feltor	City of Town State Zin	Code)
, N	s 1 and 2 f Health ftem 27 i	-	20b. Place of Disposition 20b. Place of Disposition (Name of		20c. Location - City or To	
OE .	Peges nent of I mt: If Its iry or o		Cemetery, crematory or other place)	L/14/05 E	el Air, MD	
Balti	permit. Peges Depertment of I Important: If Ite any injury or o		21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Harkins Funeral Hone, I	inc.,600 Ma	ain St.,Delta,	PA 17314
	Physician /Medical Examiner	ler.	23 Fan. Enter the disease of complication in structures allock, or heart feilure. List only one ceuse on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as e consequence of):	or respiratory arre	st,	Approximete interval Between Onset and Death
98760,	cete be physicle the bur	edicai Examiner	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of):			- F)
Box 6	eath certifii attending p	Physician/Me	d			
	death	sicia	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did to	becco use contribute t	o the cause of death?
s, P.O	s that the de gned by the so deteched		Severe Multinfarction Demention	1 TY	98 2 No 3 Pro	babiy 4 ☐ Unknown
Vital Records,	2 S W	Completed by	Severe Oropharyngeal Pysphagia	24a. Was ar perform	ned? av	lere autopsy findings vailable prior to ompletion of cause death?
E H	F e e		25. Was case referred to medical 26. Place of Deat	1 ☐ Ye	-717	□Yes 2□No
₹	ysicisn: is certifica director,	o Be	examiner?		nce 6 □Other (Speci	fy)
on of	£ £ 9	tion: T	27. Manner of Death 1-□ Natural 5 □ Pending (Month, Dey Year) 28a. Date of Injury 28b. Time of Injury Work? 1 □ Accident investigation 28a. Date of Injury 28b. Time of Injury Work? 1 □ Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	s effer dee i Director of in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Str City or Town	reet and Number or Run n, State)	al Route Number,
	To the Hospital or Attending I within 24 hours efter deeth. To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred manner stated.	red et the time, da	ate and place, and due t	o the cause(s)
	withi To th	Ž	29b. Signature and title of certifier 29c. License number	29	9d. Date signed (Month,	Day, Year)
	10		30. Name end address of person who completed gause of deeth (Item 23e) (Type, Print)	Cont	anuary	11 2005
	Ψ		Manuel M. Lazatin MD & Can SIV	ee!	Roevaeen	, Haryant
	Sta Registr		31. Dete filed (Month, Day, Year) 32. Registrar's Signeture			,

Ruth arenolal

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2005 **Physician** Jan. 7:30 p. ANTHONY PAUL ANZULEWICZ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Timonium 205 Eastspring Road 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 22,1919 Pennsylvania 7. Age (In vrs. last birthday 5. Social Security Number 6 Sex 1 ☐ M 2 ☐ F **Funeral** Days Hours Yrs. Jan. 178-05-5188 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a State or 28a-f show other treumatic event, the Medical Examiner roust be notified at 1 ☐ Yes 2 ☐ No Director Baltimore Timonium Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 U.S.A. 205 Eastspring Road Items 23a Completed by Funerai filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 □ No
If Yes, Give
Year or Dates: WW 11 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Manufacturer Company Machinist 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental snt: If item 27 Is marked o ANZULEWICZ VICTORIA SKIBOWOSKA JOHN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 205 Eastspring Road Timonium, Maryland 21093 Mrs. Julia Anzulewicz (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Gardens of Faith Cemetery 1/18/05 Rosedale Maryland Department of Importent: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 f Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line eath. Do not enter the mode of dying, such as cardiac or respiratory arrest t and Do Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner ig physician and as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ 23e. Did tobacco use copyribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 **1** No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital To the Hospitel or Attending Physician: 25. Was case referred medical examiner? 26. Place of Death Check on one) Be Other: 4 Nursing Home Hospital: 5 VHesidence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 ☐ Other (Specify) 1 🗌 Yes 2 27. Mann or atural this 28b. Time of 28d. Describe how injury occurred of Death 28c Injury at Work? After 1 Certification: Injury 5 Pending 1 Tyes 2 No after death. investigation 2 Accident 6 Could ot be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours a To the Funerel (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Y

30. Name and address of person who completed cause

death (Hen 23a) (Type, Print)

strar's Signature

32. Re

2005

29t. Date signed (Month, Day, Year).

			For State Registrer	State of	Maryland		artment of F		nd Me	ntal Hy	gien Reg. N	ZUU:	5 0	1006
	a :		Decedent's Name (First, Middle	e, Last)						. Date of De		av Vaa		Time of Death
	Physici /Medio		Dorian D. Ar	nold						JÄNUAF	RY 1	Ž, 2005	6:	:33 P M
}	Examir		4a. Facility Name (If not institution 3360 WILKENS A		oer)		4b. City, Town, o		Ϋ́			c. County of De	eath	
	Funeral		5. Social Security Number		Age (In yrs. Ia		If Under 1 Year Months Days	If Under 2	Min. 8.	Date of Bi (Month, D Jul 2	rth ay, Year	9. E	Country) 🗀	State or Foreign
	Director		501-54-2207	1 X M 2□ F	57	Yrs.				Jul 2	22,	1947	Bél	ize
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation						10d. In	side City Limits
	Maryl f sho	5	Maryland n/a		Ba	ltimor	e						11	Yes 2□No
	28a-	rec	10e. Street and Number				10f. Zip Code				10g. C	itizen of What	Country?	
	3a or	Ö	3360 Wilkens Av	zenue			2122	9				USA		
	death	Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.S	S. 13.	Was Decedent of H	lispanic Orig	in? (Specif	y Yes or N	0-	14. Race - Ar Black, W		Jian,
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28a-f show ther then "naturel", or Items 23a or 28a-f show ont, the Medical Executrae.	ğ	1 Never Married 2 Mar 3 Widowed 4 Divorced	ried 1 TYes 2	□No	}	1 X Yes 2 □ No			ral A	meri		Whi	te
2-0	72 ho	Completed		nt's Education st grade completed)		16a. Dece	dent's Usual Occup	ation during most	of working		16b.	Kind of Busine	ss/Industry	
21	ithin 19.	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use retire	d)						
	filed with Hygiene. ther than		12	(P	ainter	19 Motho	r'a Nama //	Cient Middle		use Pai n Sumame)	nting	
Maryland	ould be fi Mental H arkad ott atic aver	Be	17. Father's Name (First, Middle,	Last)				To. MOLITER						
Ĕ	hould d Men marka matic	L 2	Richard Arnold 19a. Informant's Name/Relations	chin (Type Print)		10h Mailir	ng Address (Street	and Number		civida			Zin Code	
Ma	d 2 sho th and I th sma trauma		Josef Ivor Arna				Colonel							
	es 1 and 2 of Health of Health I itam 27 I		20a. Method of Disposition	i Guizai	20b. Pl	ace of Dispo	sition (Name of		Dat Dat			ocation - City		
ē	Pages nent of h int: If its		1 Burial 2 XCremation 4 Donation 5 Other (S		ate	-	natory or other pla Crematory		1/19/0	05	Bal	timore,	Mar	vland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show minportant: If item 27 is marked other than "natural", or Itams 23a or 28a-f show yr joilury or other traumatic avent, the Medical Exercises must be notified at ance.			gnatule of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Ind. 4107 Wilkens Avenue, Baltimore, Maryland										nc.
			23a. Part1. Enter the disease, o	r complications that cau	ised the death							le, Mar		oximate
	f		shock, or heart failure. List Immediate Cause (Final	t only one cause on eac	ch line.		_							val Between et and Death
	Fnysician /Medical		disease or condition resulting in death)	a			ARDIOVAS	CULAR	DISEA	ASE				-
Е	Examiner			Due to (or	r as a consequ	ience or):								
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or	as a consequ	ence of):							-	
	uted	Examiner	Cause (Disease or injury that initiated events	S .										
o,	exec an an rial-tr	Exa	resulting in death) Last	Due to (or	as a consequ	ence of):								
8760,	cate be executed physician and the burial-transit	dical		d									-	
Θ	artifica ing pt	O O	IF FEMALE:								· · · · I			
P.O. Box	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2∏Fetal nt at time of de	death 3[Ectopic pregnanc Other (specify)	<i>y</i>				23d. Date of o Month	delivery Day	Year
	that led by deta	y Ph	Part II. Other significant conditi	ons contributing to dea	th but not resu	itting in the u	nderlying cause giv	en in Part I.		23e. Did	tobacco	use contribute	to the cau	ise of death?
rds	quires n sign	d by								1 🗆	Yes 2	2 □ No 3 □	Probably	4 X Unknown
Records,	s bee	Completed								24a. Wa		24b. Were	autopsy fi	ndings available
Be	The lav	mo								perf	opsy ormed? 2 X N	death	o completi ? es 2 1	ndings available ion of cause of
Vital		l o	25. Was case referred to medica	al				26. Place	of Death (Check only				
of V	ys diis	To B	examiner? 14∑ Yes 2 ☐ No	Hospital: 1 ☐ Ing	oatient 2 🗆 E	ER/Outpatie	nt 3□ DOA Ott	ier: 4 □ Nui	rsing Home	5 Res	idence	Other (S	pecify) SC	CENE
0	ng Pl		27. Manner of Death 125 Natural 5 ☐ Pendi	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury	Wo			d. Describe	how inj	ury occurred		
Sio	Attending r death. ector: After by the fune	catle		igation not be				Yes 2 1					0. (0.	
Division	in the	Certification:	4 Homicide determ	nined 289, Place o	f Injury - At ho g, etc. (Specify	me, farm, sti	eet, factory, office		28	City or To		and Number or te)	Hural Hou	:e Number,
	pital ours a aral [2	29a. Certifier 1☐_Certifyi	ng Physician: To the b	nost of my know	wledge deat	h accurred at the ti	ma data and	d place, an	d due to the	031150/	s) and manner	as stated	
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical	(Check only one)	Exeminer: On the bas and manne	is of examinat	ion and/or in	vestigation, in my	pinion, deat	h occurred	at the time	, date a	nd place, and o	lue to the o	:ause(s)
	o the	₩	29b. Signature and title of certific	er \			29c. Licens	e number		1	29d. D	ate signed (Mo	onth, Day,	Year)
			1-11	UE	War			ΜE				UARY 13		
	A		30. Name and address of persor THEODORE KING	who completed cause	of theath (Item	23а) (Туре,	Print) 111 PEN	N STRE	EET, E	BALTIM	10RE	, MARYI	AND,	21201
•	Sta		31. Date filed (Month, Day, Year	32. Reg	gifrar's Signat	ture	Sparle					,	,	
	Regist	rar	JAN 1	9 2005	BAZIA -	100								

State of Maryland / Department of Health and Mental Hygiene 005 For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 14, 2005 **Physician ANDELMAN** 4:19 AΜ MARION /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE COCKEYSVILLE CATERED LIVING OF COCKEYSVILLE 8. Date of Birth (Month, Pay, Year) FEB. 4, 1918 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 ☑ F Months Days Hours NJ 86 150-09-3478 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State item 27 le marked other then "neturel", or Items 23s or 28s-1 show other traumatic event. The Mardical Express. I ust be inclified at 1 ☐ Yes 2 📉 No Director BALTIMORE COCKEYSVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21030 10881 YORK ROAD Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔏 No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify: Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be pe Mental and Mental **GREEN** UNKNOWN UNKNOWN UNKNOWN 2 Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 121 EAST CLEMENT STREET - BALTIMORE, MD 21230 item 27 WILLIAM ANDELMAN / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 0 = 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. WASHINGTON, DC ADAS ISRAEL CONGREGATION 1/16/2005 ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part 1. En 4r the of ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart ladure. List only one cause on each line. Immediate cause (Final disease or condition resulting in death) nelmers 4944 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a nonsequence of Examiner death certificate be executed burial-transi Due to (or as a consequence of): physician Physician/Medical the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ō 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2\2\No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 ther (Specify) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No this After th funeral Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Hospitel or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide n 24 hours the Funerel Dire 29a. Certifier cai 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Pay, Year) 29b. Signature ar Greature Battompalo 30. Name and address of person 32. Registra Signature Year) The state of Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of	Marylan	_	artment rtificate			and M		giene Reg. No.	200	5 01008
	Dhusisi		1. Decedent's Name (First, Middle	e, Last)							Date of De. Month	ath Day	Year	3. Time of Death
	Physici /Medio		JOHN	MURRAY		BRA	DLEY				Jan.		005	2:30 p. M
	Examin	er	4a. Facility Name (If not institution	*			4b. City,		Location o	of Death			County of De	
			12563 Dulaney		. Age (In yrs. I	lact hirthday	If Under	Phoe	enlx If Under:	24 Hrs.	8. Date of Birt	_	altimo	
Н	Funeral		5. Social Security Number 219–10–3575	1.59X /	77	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)		irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	Λ							Oct. 18	5,192	./Mai	ryland
	ow ow		10a. State 10b. County	-	10c. City	y, Town or Lo	ocation							10d. Inside City Limits
	Many Filed	ţ	Maryland Balti	more	I	Phoeni	x							1 ☐ Yes 2 ☐ No
	death with the Marylend me 23a or 28a-f ahow Friust be notified at	Funeral Director	10e. Street and Number		•		10f. Zip	Code				10g. Citiz	en of What (Country?
	h wit	a D	12563 Dulaney V	Valley Road	1		21:	131				U.S	.A.	
	dea T	ner	11. Marital Status	12. Was Deced	lent Ever in U.	.S. 13.	Was Deced	ent of His	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	- 1	 Race - An Black, Wh 	nerican Indian, nite, etc.
9	or It	F	1 ☐ Never Married 2 ☐ Marr	ried 1 XYes 2	. □ No		1 ☐ Yes 2		Specify:				Specify:	White
215-0036	n 72 hours after death with the Maryler "natural", or Itama 23e or 28e-f ahow edical Exertinar rival be notified at	d by	3 Widowed 4 Divorced		es: WW 11				41			10h Kin	d of Duning	
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7	within ene. then "	립	Elementary/Secondary (0-12)	College (1-		Real		, , , , , ,				Rea	l Esta	ate
d 21	Hygie thar		17. Father's Name (First, Middle,						18. Mothe	r's Name	(First, Middle,			
an	d be ental ked o) Be	Thomas Jose		J				Hi	lda i	Edna Du	ılane	V	
Maryland	s i end 2 should be filled within f Heelth and Mental Hyglene. Itam 27 is marked othar than other traumatic avant, Ita M	၉	19a. Informant's Name/Relations	•	-	19b. Maili	ng Address	(Street a			Route Numbe			, Zip Code)
Za	d 2 s th an trau		Mrs. Alice Brad)	1256	3 Dula	anev	Vall	ev Ro	ad Pho	enix	. Marv 1	Land 21131
	permit. Pages 1 end 2 Department of Heeith a Important: If Itam 27 is any Injury or other tra ange.	1	20a. Method of Disposition		20b, P	lace of Dispo	sition (Nam	ne of			ate			or Town, State
ᅙ	ages ont of t: If if		1. Burial 2 Cremation 4 Donation 5 Other (S		iate	emetery, crei John Ca	_			1/18/0	15	Hal	es Mary	land
Baltimore,	artme ortan		21. Signature of Funeral Service	-	100.		2. Name an	d Addres	s of Facilit	v		Пус	S, PELY.	Ialu
Ba	permit. Departr Importa any Inju		1 Dut	milka	7		Mitche	≥LL-Wi	edefe	ld F.H	l. Inc. ore Mary	dand '	21212	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca	used the death	h. Do not ent							21212	Approximate Interval Between
	41-1-1		shock, or heart failure. List Immediate Cause (Final											Onset and Death
T	Proysician / /Medical		disease or condition resulting in death)	a. Due to (a	r as a consequ	DIAL	IN	FAN	900	<i>P</i>				NONE
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		- e	Sequentially list conditions, if any, leading to immediate	b. Due to (o	r as a consequ	uence of):	C 000	105						
	thed tradit	Examiner	if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events	S										
Ć,	exect n and lai-tra	Exa	resulting in death) Last	Due to (o	r as a consequ	uence of):								
8760,	certificate be executed Iding physicien and ise es the burial-tranait	Ical		d										
ø	ificat g phy es the		_											
Box	eath certific attending pi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc	ome of pregna th 2 DFetal		DEctopic pro					2:	3d. Date of d	•
-	d for	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregna	nt at time of de		Other (sp						Month	Day Year
P.0	res that the de signed by the a I be detached f	hys	9 Unknown	9□ Unknov	٧n									
	s tha	by P	Part II. Other significant condition	ons contributing to dea	th but not resi	ulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	obacco us		to the cause of death?
Ę	quire on sig vid b	Pe	ATRIAL	FIBRILLA	710N						101	es 2K	JMp 3⊟t	Probably 4 Unknown
Records,	law requires that the death as been signed by the atter 2 should be detached for u	Completed									24a. Was		24b. Were a	autopsy findings available completion of cause of
	The is ate ha page 2	E									perfo	rmed? 2 X No	death?	es 2 No
of Vital	reiclen: The iaw s certificate has b lirector, page 2 s	0	25. Was case referred to medica	1					26. Place	of Death	(Check only o	_		
>	yaicl s cer direc	To B	examiner?	Hospital: 1 1n	patient 2	ER/Outpatier	nt 3 DO	Othe	IT. 4 □ Nu	rsing Hom	ne 5 Hesio	dence 6	☐Other (Sp	ecify)
0	g Physer this erral dir		27. Manner of Death	28a. Date of	Injury Day Year)	28b. Time o	f 2	8c. Injury Work	at	2	8d. Describe	now injury	occurred	
Division	ath. r: Aff	atlo	Natural 5 Pendin Pendin Pendin	·9	,, , ,	,,	М		/es 2 □	No				
<u><i< u=""></i<></u>	or de	# E	3 Suicide 6 Could 4 Homicide determ	inad 200. Place	of Injury - At ho g, etc. (Specify	ome, farm, str	reet, factory	, office		2	8f. Location (S City or Tox		Number or F	Rural Route Number,
	saft al Di	Certification;												
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifyir	ng Physician: To the base	est of my kno	wiedge, deat	h occurred a	at the tim	e, date an	d place, a	nd due to the	cause(s) a	and manner a	as stated. ue to the cause(s)
	the H the F the F	Medical		and manny	la manata ad		_							
	S T S	2	29b. Signature and title of certifie	r			290	. License	number	2 0		290. Date	signea (Moi	nth, Day, Year)
	4		160					P	11	20		14	IN I	1,2005
-	10		30. Name and address of person	who completed cause	of death (Item	23a) (Type,	Print)	115	1 07	- 0	1 3	40.	2 12 1	ı
	\		CAM CEN	16 (07).	6 / 6	/ /	- ter	AN B	//	~	Mr.	100	uly	
3.	Sta		31. Date filed (Month, Day, Year)	who completed cause	gistrar's Signa	iture J.	STORA .	2						
91	Registr	ar	JAN	T 0 C000 3			7							

		-	For State Registrar	State of Marylar			nt of He te of D			ene 2	005	0 1	009
4		T)	Decedent's Name (First, Middle, Last	t)					2. Date of Death Month	Day	Year	3. Time	of Death
	Physicia	_	Mary Lillian By:	cne					January			1:03	P M
1	/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City	, Town, or I	Location of Death	1	4c. Co	inty of Death		
	_Admini		Maria Health Ca:	re Center			altim			Bal	timore	;	
Ą	Funeral		Social Security Number 6. Social Security Number	7. Age (In yrs		If Unde Months		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State ntry)	or Foreign
٠ 	Director		215-09-5283		37 Yrs.				Sep 21, 1	917	М	ID	
	pur »	-	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or L	ocation						10d. Inside	City Limits
	faryli sho	5		imore	Baltim	nore						1	s XX No
	the N	Director	10e. Street and Number			10f. Zi	p Code		10	g. Citizen	of What Cou	ntry?	
	with with		6401 N. Charles	St.			21	212			USA		
	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. do ther than "natural", or flems 23a or 28e-f show do ther than "natural", or flems 23a or 28e-f show event, the Medical Examinar must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Dece	edent of His	spanic Origin? (S	pecify Yes or No- o Rican, etc.)		Race - Ameri Black, White,		
۵	or Ite	F	1XXIever Mamied 2 ☐ Married	Armed Forces? 1 ☐ Yes 2XXNo			2XXNo		o rican, ecc.)		ecity: Whi		
21215-0036	ours a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		10 103	26/210	эрвопу.					
<u>ئ</u>	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		(Give	e kind of w	ual Occupa ork done di	uring most of wor		6b. Kind	of Business/In	ndustry	
7	ithin	du	Elementary/Secondary (0-12)	College (1-4or 5+)	inte.		use retired)					1 1	
2	filed within Hygiene. other than " ent, It a Me		17. Father's Name (First, Middle, Last)	5+	1	tead	cher	18 Mother's Nan	pa ne (First, Middle, M		ial sc	NOOT	
פענ	ould be fi Mental H arked ot latic ever	Be	John J. Byrne						ian E. Ki		,		
ج	2 should be and Mental is marked c	2	19a. Informant's Name/Relationship (Type Print)	19b. Mail	ling Addres	ss (Street a		ıral Route Number,		wn, State, Zij	p Code)	
Maryland	nd 2 s		Bernice Feiling						Baltimor				
ō,	1 a Hea	l	20a. Method of Disposition		Place of Disp	osition (Na	ame of	1			ion - City or T		
ᅙ	Pages nent of int: If it		1 🖾 Burial 2 □ Cremation 3 □ * ♣ □ Donation 5 □ Other (Specified)		illa Ma				14/05	len	Arm, M	D	
Baltimore,			2) Signature of Funeral Solvice Licer		2	22. Name a	and Address	s of Facility					
n	permit. Departr Importa any inji		Almeni der k	1. Kenaki		Mitch	ell-W Vork	iedefeld Road. Ba	Funeral ltimore,	Home	1212		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only		th. Do not en	nter the mo	de of dying	, such as cardiad	or respiratory arre	st,		Approxim Interval B	etween
	Physician		Immediale Cause (Final	Asa.	hetes	M	ellit	4			4	Onset and	d Death
	/Medical		disease or condition resulting in death)	Due to (or as a conse	quence of):	, ,-,-	1		4 4 4 4 4		,		
	Examiner		O Section Market and Miles	Due to (or as a conse	nas	za	400	ry we	sis file	(0)			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):			0					
	ate be executed hysicien and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
/60,	e exe		resulting in death) Last	Due to (or as a conse	quence or):								
8	physic physic the b	dical		d									
Ø X	death certifica e attending ph id for use as tl	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregi	nancy					23d	. Date of deliv	/ATV	
Box	attenc for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fe	tal death 3	□Ectopic □ Other (s				250	Month	Day	Year
o.		ysic	1 □ Yes	9□ Unknown	30231								
2	The law requires that the ste has been signed by th bage 2 should be detache	H.	Part II. Other significant conditions of	ontnbuting to death but not re	sulting in the	underlying	cause give	n in Part I.	23e. Did tob	acco use	contribute to	the cause o	f death?
Records,	uires sign lid be	d by							1 🗆 Ye	s XeX	io 3□Pro	bably 4	Unknown
Ö	w require been si should b	Completed							24a. Was an	2	4b. Were aul	opsy finding	s available
He	The lay	LL O							autopsy perform 1 ☐ Yes 💥	ed?	death?		Cause of
ta		0	25. Was case referred to medical					26. Place of De	ath (Check only one				
>	Physician: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 [X]No	Hospital: 1 ☐ Inpalient 2	□ ER/Outpatie	ent 3 🗆 🛭	Othe Othe	r: 4XXNursing H	lome 5 ☐ Reside	nce 6	Other (Speci	ify)	
0	ding Ph h. After th funeral	l:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury		28c. Injury Work	at	28d. Describe ho	w injury o	ccurred		
Ö	Attending ir death. ector: After by the fune	atic	2 ☐ Accident investigatio			М	101	res 2□No					
Division of Vital	or Attendate death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be determined			street, facto	ory, office		28f. Location (Str City or Town,		lumber or Rui	al Route Nu	imber,
	res at			1									
	Hosp 4 hou Fune Fely fi	icai	(Check only 2 Medical Example (Check only 2 Medical Example)	nysician: To the best of my kinner: On the basis of exami	nowledge, dea nation and/or i	ath occurre investigation	od at the timon, in my op	ie, date and place pinion, death occi	e, and due to the ca urred at the time, da	use(s) an te and pla	d manner as a ace, and due	stated. to the cause	e(s)
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	one) 29b. Signature and title of certifier	and manner stated.		2	9c. License	number	29	d. Date s	igned (Month	Day, Year,)
	N I S		Daniel	/ (len as	100			co/33	7	1/	12/0	5	
_	\		30. Name and address of person who	completed cause of death /It-	am 23a)/Type	Print)		, , , ,	(-/-	-	-	
	\		Francis X. Carme	3 3505	0 = 1 =		e, Bai	ltimore.	MD 21204				
	Sta	ate	31. Date filed (Month, Day, Year)	32 Begis ar's Sig	nature .	Ano	1						
	Regist		JAN 1 S	2005 A Color	1 180	Form	NOTE !						

		•	For State Registrar	State	of Mary	land / Dep <i>Ce</i>	artmen e <i>rtificat</i>	it of H	ealth D <i>eath</i>	and M		giene () Reg. No.	105	01010
			Decedent's Name (First, Middle	, Last)							2. Date of De		Year	3. Time of Death
	Physici /Medio		Hilda Goode Belo	cher							JANU		7 2005	5 9:00 AM
	Examin	er	4a. Facility Name (If not institution		umber)				Location	of Death			inty of Death	h
			Union Memorial I 5. Social Security Number	lospital 6. Sex	7 Ago //o	yrs. last birthday		timo	re If Under	24 Hrs	8. Date of Bir	N/		nplace (State or Foreign
	Funeral Director		151-34-1108	1 M 2 M F	7. Age (#/	99 Yrs.	Months		Hours	Min.	June 7	y, Year)	Col	rginia Cginia
			Usual Residence of Decedent								June 7	, 1905		
	ırylan show	_	Maryland N/A			c. City, Town or 1 $a1 { m timore}$								10d. Inside City Limits 1XXYes 2 □ No
	8a-f s	Sch				arcinore							4140	
	with ti	吉	10e. Street and Number 830 W. 40th St.				10f. Zip	211				10g. Citizen	ed Sta	•
	ns 23	Funeral Director	11. Marital Status	12. Was Dec	cedent Ever	in U.S. 13	. Was Dece	dent of Hi	spanic Or	igin? (Sp	ecify Yes or No)- 14. E	Race - Amer	rican Indian,
9	or Iter	듄	1 ☐ Never Married 2 ☐ Marri	Armed F ed 1 ☐ Yes If Yes, G	2 X No		If Yes, spe	cify Cuba	n, Mexica	n, Puerto	Rican, etc.)		Black, White	
03	ours a	d by	3 X Widowed 4 □ Divorced	Year or	Dates:		1 🗆 Yes	2 X NO	Specify.					ite
5-("natu	Completed by	15. Decedent (Specify only highes	's Education t grade completed)	16a. Dec	edent's Usua e <i>kind of wo</i> DO NOT u	al Occupa	ation Ju <i>ring m</i> os	st of work	ing	16b. Kind o	of Business/I	ndustry
72	withir ene. than	E C	Elementary/Secondary (0-12)	College	(1-4or 5+)		egiste					medi	ca1	
9	filed Hygi other	Be C	17. Father's Name (First, Middle,	Last)			201000	Luu	18. Moth	er's Name	(First, Middle	, Maiden Sun		
ılan	uid be Aenta rked tic ev	To B	Henry Hobson Go	ode					Ger	trude	e Mosel	ey		
lary	2 short and halls ma		19a. Informant's Name/Relations			Į.	•				al Route Numb			
`≥	and lealth m 27 her tr		David Belcher/s	on	2	3806 0b. Place of Disp	St.		St.		altimor		21218 on - City or T	
ore	in of h		20a. Method of Disposition 1 Burial 2 Cremation		State	cemetery, cr	ematory or o	other plac					,	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinar must be millied at once.		* 4 □Donation 5 □Other (S _i 21. Signature of Funeral Service I		G		22 Name or	al Address	a of Facili	in .				, Maryland
Ba	Depril Impo		Defen 8. M	tickell	Δ <u>L</u>		Mi 65	tche	11-W	iede:	feld Fu Balti	neral i	Home,	Inc.
			23a. art1. Enter the disease, or shock, or heart failure. List	complications that	caused the	death. Do not e	nter the mod	de of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			um Dil	===(//	E -	7/2V10	11156	100000	,		Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a co	nsequence of):	1 1010		COAIC	meg	1000070			
	LAGITITIE	1	Sequentially list conditions,	b. ATR	IAL	FIBRILL nsequence of):	ATION	J						
	rted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury						010.1	·				
W.S	execu in and ial-tra	Exal	that initiated events resulting in death) Last	C. Due to	o (or as a co	SOTRICO	CCAR	THICU	YYLFOLL					
8760,	eath certificate be executed attending physician and for use as the burial-transit	dical		L d										
9	artifica ing ph e as th	Med	IF FEMALE:											
80)	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?		birth 2 🗌	Fetal death 3	□Ectopic pi					23d.	Date of deli- Month	very Day Year
o.	at the death by the atter stached for u	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	9□ Unki	nant at time nown	ordeam 5	Other (sp	эвспу)						
Division of Vital Records, P.O. Box	Physician: The law requires that the death certific this certificate has been signed by the attending r ral director, page 2 should be detached for use as	by Physician/Me	Part II. Other significant condition	ns contributing to	death but no	t resulting in the	underlying c	ause give	n in Part	l.	23e. Did t	obacco use c	ontribute to	the cause of death?
rds	w requires been sign should be										1 🗆 '	Yes No	o 3∏Pro	obably 4 Unknown
ဝ၁	ne law re has bee ge 2 sho	Completed									24a. Was		b. Were aut	topsy findings available ompletion of cause of
Ä	ysician: The is certificate hadirector, page	Com										22No	death? 1 ☐ Yes	2 No
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth	. 67		(Check only o			
of	Physic this cral dir	2	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	•	2 ER/Outpatie		Othe 28c. Injury	4 L INI		me 5 Residence R			ufy)
on	ding th. : After	tion	Natural 5 Pendin	g (Mo	nth, Day Yea	ar) Injury	м	Work	:? ∕es 2 🗆			,		
Visi	Attern dea ector	ifica	3 Suicide 6 Could r	ned 288. Plac	e of Injury -	At home, farm, s	treet, factory	y, office			28f. Location (;	Street and Nu	ımber or Ru	ral Route Number,
ا	tal or	Certification:												
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier (Check only one) 1 Certifyin 2 Medicel	g Physicien: To the Examiner: On the	basis of exa	y knowledge, dea mination and/or i	ith occurred nvestigation	at the tim , in my or	e, date ar pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) and date and plac	manner as ce, and due	stated. to the cause(s)
	o the ithin 2 o the omple	Mec	29b. Signature and title of certifier	and mai	nner stated.		290	c. License	number			29d. Date sig	ned (Month	, Day, Year)
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	V		30. Name and address of person	11	use of death	(Item 23a) (Type		U 7/	W7.7	5001	WUXI	HIVOLA	7	1, 2000
			KIMBERLY WALL	ACE 201		INIVERSI	TY PA	KKW	AY	754L	TIMORE,	MA .	21218	,
	Sta Registr		31. Date filed (Month Day, Year)	2005	egistrar's S	signature	De la	•	(
	3.0			150	,	- 1								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Dorothy Burd January 12, 2005 2:35 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Springbrook Nursing Center Silver Spring If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 200 F Yrs. 60 Director 085-36-5560 July 26, 1944 New York Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28e-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Silver Spring Maryland Montgomery Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 2103 Glenallen Ave. #T-2 230 United States death Funeral І_{тет} 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Mamed 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Law Office Legal Secretary 12 permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis important: if item 27 is marked other 1 any injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Burd Ruth E. 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John W. Burd / Brother 202 Parkside Ave., Readin, PA 19607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 1/14/05 Beltsville, MD 22. Name and Address of Facility Rapp Funeral and Cremation Services Filet Johnson M0038Z 933 Gist Ave., Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Prysician End Stage Renal Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner burial-transit certificate be executed Due to (or as a consequence of) nding physicien Physician/Medical as the l IF FEMALE: use : 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy the atter jo Month Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown been signed by ta should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificate 1 Yes 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) No 1 Yes 2 this funeral 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation after death.

i Director: Af
d in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a To the Funerei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) January 16, 2005 D41715 ress of person completed cause of death (Item 23a) (Type, Print) 6201 Greenbelt Rd. #3, College Park, MD 20710 Chitra Venkatraman M.D. 31. Date filed (Month, Play, Year) 32 Registrar's Signature State Registrar

		State of Maryland / Department of Healt 1- State Registrar Certificate of Dealt	th and Me	ental Hygi	ene 00	5 01012
Physicia	m	1. Decedent's Name (First, Middle, Last)		Date of Death Month		3. Time of Death
/Medic		Simon Brockenbrough	No. of Seath	January		2:50 9 M
Examin	er	4a. Facility Name (If not institution, give street and number) Stella Maris-Mercy 4b. City, Town, or Locat Baltimor		1	4c. County of N/	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year 1 Hours 231-32-2860 1 M 2 G F 75 Yrs.		8. Date of Birth (Month, Day,)	(ear) 1929	D. Birthplace (State or Foreign Country) VA
and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
1215-0036 within 72 hours after death with the Maryland ene. han "natural; or items 23e or 28e-f show the Medical Exercit er must be motified at	ţo	MD N/A Baltimore				1√XYes 2 □ No
th the or 28a e noti	irec	10e. Street and Number 10f. Zip Code		10	g. Citizen of Wh	at Country?
ath wi	rai	709 Mura Street 21202			USA	
or des	nne	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent of Hispanic If Yes, specify Cuban, Mexical Indicators and Indicators	ic Origin? (Spec exican, Puerto F	cify Yes or No- Rican, etc.)		American Indian, White, etc.
Stron	by F	1 ☐ Never Married 2 Married 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	ecify:		Specify:	Black
5-0 5-0 72 ho	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during	most of workin	10	6b. Kind of Busi	ness/Industry
2 2 Eight	mpie	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)			Variou	ıs
d 2.	ပ္ပ	7th N/A Construction 17. Father's Name (First, Middle, Last) 18. M	Mother's Name	(First, Middle, Ma		
ld be lental ked o	To Be	William Jefferson Brockenbrough	Savan	nah	Temple	:
S S S S S S S S S S S S S S S S S S S	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and No.	lumber or Rural	Route Number,	City or Town, St	ate, Zip Code)
and 2 mark m 27 liber tre		Ella Brockenbrough-wife 709 Mura St. Ba			21202	
Baltimore, Management. Pages 1 and 2 permit. Pages 1 and 2 permit. Pages 11 and 2 important; if them 27 is any lnjury or other treasure.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory of other place)				ty or Town, State
Itim iit. Pa artmer ortant injury		4 □Donation 5 □Other (Specify) King Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of F	1/19/	CH FUNER	Randalls	
Bal permi Depa impo any li		& lades 42 amer 1101 E. North	11111			
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.				Approximate Interval Between
Physician		Immediate Cause (Final disease or condition MP tastatic Ki	Enen c	me		Onset and Death
/Medical Examiner		Due to (or as a consequence of):				
	e.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events C.				
8760, ate be executed hysician and the burial-transit	Ex	resulting in death) Last Due to (or as a consequence of):				
876 cate b physic the bu	dical	d				
Box 68 leath certificat attending phy of for use as th	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date	of delivery
P.O. BOX that the death cered by the attendir detached for use	by Physician/Med	in the past 12 months? 1 Vec. 2 No. 4 Pregnant at time of death 5 Other (specify)			Month	•
at the dathe datached	hys	9 □Unknown		T		
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Part I.	23e. Did toba		ute to the cause of death? Probably 4 Unknown
Cords, w requires been sign	eted			24a. Was an		re autopsy findings available
Rec he fav e has ige 2 s	Completed			autopsy performe	ed? pric	or to completion of cause of th?
an: T	Be Co	25. Was case referred to medical 26. P	Place of Death	(Check only one)		Yes 2□ No
f Vi	To B		☐ Nursing Hom	ne 5 ☐ Residen	ce 6 dother	(Specify) hospice
ing Pl	ou:	27. Manner of Death 1 ☑Natural 5 ☑ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?		8d. Describe how	injury occurred	
isio	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined determined	2NO	8f. Location (Stre	et and Number	or Rural Route Number,
Div after dinby	ertil	4 Homicide determined building, etc. (Specify)		City or Town,		
Division of Vital Rec Division of Vital Rec To the Hospital or Attending Physician: The fav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dat 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	ite and place, ai	nd due to the cau d at the time, date	se(s) and mann e and place, and	er as stated. I due to the cause(s)
To the within 2 To the comple	Ĭ	29b. Signature and title of certifier 29c. License numb	ber	290	d. Date signed (i	Month, Day, Year)
		DH088	54		1/17/2	NO5
		30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	a lLim	ave m	1 7	1272
Stat	e	Scrip Riseberg 301 ST paul pl Ba 31. Date filed (Month, Day, Year) 32. Registrar's Signature	4 I KIM	GVT M	01.	ICOC
Registra		JAN 19 MAR ARAD BE ANDER				

State of Maryland / Department of Health and Mental Hygien® 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 8:35 p M BROUSE 2005 ARY /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Riverview Care Center Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Yea Jul 3, 19 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sax **Funeral** Months 1□ M 2QF Yrs. 214-12-3947 82 Maryland Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ir than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland n/a Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 406 Greenland Beach Road 21226 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Healin and Mental Hygiene. Importent: If fam 27 is marked other than "natural", or flan any injury or other trainmetr. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: WHite þ 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0 Retai] Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Louis Dabney Mary Hartman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Carnaggio / Son 406 Greenland Beach Road, Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Cemetery 1/17/2005 Middle River, Md. 4 □ Donation 5 □ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Deneube Physician 4 4 a 65 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last that the death certificate be execu Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical as the use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Linkney Completed 24b. Were autopsy findings available prior to completion of cause of death? Peripheral Unicular Dirace 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 NO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 2 1 Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Hospital or Attending 5 Pending investigation 1 Hatural 1 ☐ Yes 2 ☐ No death. 2 Accident 28f. Location (Street and Number or Rural Route Number City or Town, State) 6 ☐ Could not be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1-15-2005 D19667 Checoop 29 Cables 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 730 Pitdie Hylework 508 Glecitorico. (Carried 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 9 2005 Dept. Registrar

			For	State of Marylar				nd Me	ntal Hy	giene	A F	0 1 0 1 1
			1 - State Registrar		Ce	rtificate of L	Death		F	Reg. No.	05	0 0 14
	Physici	200	1. Decedent's Name (First, Middle, Las.)				2	. Date of Dea Month	nth Day	Year	3. Time of Death
	/Medic		CHIFFON	BARRETT		T			anuar		005	3° p.
0.	Examin	er	4a. Facility Name (If not institution, give Mary and General	street and number)	70	20 Am	- 60	Death	Ly	4c. Count	y or Death	•
4.	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24		. Date of Birti	h	9. Birthp	lace (State or Foreign
ı	Director		196-54-4223	□ M 2 XCX F	40 Yrs.	Months Days	Hours	Min.	(Month, Da) EC • 2		Coun NEV	YORK
	p ,		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	neation					1	Od. Inside City Limits
	shov	ō		100.0								1 X Yes 2 □ No
	28a-f	Director	MARYLAND N/A 10e, Street and Number		BALT	IMORE 10f. Zip Code				10g. Citizen of	What Coun	try?
	3s or		2433 WOODBROOK AV	ENUE		21217				U.S.A	A .	
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origi	in? (Specif	y Yes or No-		ce - Americ	
õ	or Ite	y Fu	1 Never Married 2 Married	1 Yes 2XNo If Yes, Give Year or Dates:		1 ☐ Yes XX No	Specify:		Jan, 5151)		^{fy:} BLAC	
1215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "natural", or Items 23c or 28s-f show event, I're Medical Exerting Italian Italian at	d by	3 Widowed 4 Divorced		163 Dece	dent's Usual Occupa	ation			16b. Kind of B		
ည် က	in 72 "nat	Completed	(Specify only highest grad	le completed)	(Give	kind of work done of DO NOT use retired,	du <i>ri</i> ng most o ')	of working		16b. Killd of E	00311163371110	lustry
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Maryland 2	should be filed within a Mental Hygiene. marked other then matic event, ILE M	Be C	17. Father's Name (First, Middle, Last)				18. Mother's	's Name (F	First, Middle,	Maiden Surnai	те)	
<u>X</u>	should be and Mental I marked o	To	MILTON OLLIE BA	RRETT SR.					WRIGH			
Nar	12 sh and n 7 Is m		19a. Informant's Name/Relationship (7)			ng Address (Street a						
	1 and Health 6m 27 ther to		Anna B. Barrett/M	20b.	Ptace of Dispe	3 Woodbro		Date		20c. Location		
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic e ance.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	cemetery, cre	matory`or other place MEMORIAL		L-22-	0.5	BALTIMO	DE MZ	APVI.AND
	nit. P artme ortan Injur 9.		21. Signature of the full Service Licent	//	2	2. Name and Addres	s of Facility					
ñ	permit. Departr Imports any Inji		1///	vaun		ILLIAM C 206 W NOR			UNITY	FUNERAL	_ HOME	E P.A.
ř	• a		23a. Part i. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea	th. Do not en	ter the mode of dying	g, such as ca	ardiac or r	espiratory an	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Cerebral	- Ar	Jeur 45	2M					Onset and Death
,	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	Hemo	ach	nn o	7			
	Examine.	J.	Sequentially list conditions,	Due to (or as a consec	JUA I	Herrio	{ 1 / 1.0	July -C				
	ited Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,							
ĵ	execunand and ial-tra	Exal	that initiated events resulting in death) Last	Due to (or as a consec	quence of):							
8/6U	icate be executed physician and s the burial-transit	dical	(d								
9	ntifica ng ph s as th	Med	IF FEMALE:									
XOR	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1☐Live birth 2☐Fet	al death 3	☐Ectopic pregnancy					ite of delive onth	ry Day Year
	at the de by the a rtached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	ueath 5	Other (specify)						
7.	res that tigned by	y Ph	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	Inderlying cause give	en in Part I.		23e. Did to	bacco use con	tribute to th	e cause of death?
ecords,	quires n sign ald be	d by							1 🗆 Y	es 2 🗆 No	3 Prob	ably 4 Unknown
000	s been si	olete							24a. Was a		Were autor	osy findings available
r	alclen: The law s certificate has b irector, page 2 s	Completed							perfor	med2	death?	
VII	striffica ctor, p	Be C	25. Was case referred to medical exampler?					of Death (Check only o	ne)		
0	this la	ဥ	1 Yes 2 No		ER/Outpatie		4 Nurs			ence 6 Ott)
	Jing After fune	:lon:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	rat ⟨? Yes 2. No		u. Describe n	ow injury occur	160	
UIVISION	death death ctor: y the	ficat	3 Suicide 6 Could not be	28e. Place of Injury - At h	nome, farm, st						ber or Rura	l Route Number,
2	To the Hospitel or Attending P within 24 hours after death. To the Funerel Director: After i completely filled in by the funers	Certification:	4 Homicide	building, etc. (Speci	ify)				City or Tow	n, State)		
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	To the Hospitel within 24 hours a To the Funeral I completely filled	ledical	one)	and manner stated.	ation and/or in			100001180				
	2 1 2 2	×	29b. Signature and title of certifier	1/1/11		29c. License		G 2		29d. Date signe		
/	18		20 Normand	Muy	m 23a) /T	Print)	374	100		113	1	, ^
1	יו ע		30. Name and address of person who of Nis Chal Rid	dy M. D.	C/0	mary	land	670	enero	1/15, al 1	LOSE	ital
	Sta	ite	31. Date filed (Month, Day, Year)	. Registrar's Sign	ature	J'						
	Registr	ar	JAN 1 9 2005	Market S.	Som	(h)						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** BAMBERGER 1230 KATHE January 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Sinai Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
DEC.17, 1909 5. Social Security Number **Funeral** Days Months Hours GERMANY 1 ☐ M 2 💢 F 220-12-7150 95 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or than "natural", or freme 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No BALTIMORE Director N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2 should be filed within 72 hours after death win and Mental Hygiene. • is marked other than "natural", or iteme 23a : 4116 FORDLEIGH ROAD 21215 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No WHITE Specify: 2 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSING PRACTICAL BABY NURSE permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Importent; if item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ULLMAN REITER IDA LE0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7458 PARK HEIGHTS AVENUE - BALTIMORE, MD 21208 JOE BAMBERGER / SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 4 Donation CHEVRA AHAVAS CHESED RANDALLSTOWN, MD 01/16/2005 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial intarction 10 days disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Hypertension

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine burial-transit Diabetes and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Minpatient 2 ER/Outpatient 1 ☐ Yes 2 XNo 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: B Hospitei or Attending P 24 hours after death. B Funerel Director; After t 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and que to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES 00 0 in macientine Do 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) West Belvedere Ave. Baltimore Ann MacIntur 31. Date filed (Month, Day, Year) 32. Reststrar's Signature State JAN 1 9 2005 RALIANI Registrar

		1	State of Maryland / Department State of Maryland / Department Certificate			Reg. No.	UIUIO
	Physicia		Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Day Year	3. Time of Death
	/Medic	al -	Katherine V. Conner 4a. Facility Name (If not institution, give street and number) 4b. City, To	own, or Location of D	January	12, 2005 4c. County of Dea	10:25 AM
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I	Funeral Director		213–10–1646 1 M XWF 95 Yrs.		Hrs. 8. Date of Birl Min. (Month, Da May 21	y, <i>Year)</i> 9. Bir Ca 1909 Ma	thplace (State or Foreign puntry) ryland
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Mary a-f sho	tor	Maryland Baltimore Parkvi	.11e			1 ☐ Yes 2 √No
	with the	ਕ ∣	10e. Street and Number Genesis ElderCare Center	.234		10g. Citizen of What C	
	death	Funeral	8/10 Emge Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decede If Yes, specific Yes, sp		n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Am Black, Whi	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heath and Mental Hygiene. If itam 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic evant, Ita Madical Evant or items to contilied at	ρ	1 The ver Married 2 Married 1	No Specify:		Specify:	white
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<u>کام</u>	should be nd Mental markad o	2	John T. Conner		cha McClel	er, City or Town, State,	Zip Code)
Mar	id 2 sh Ith and 27 is m traum	i	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (506 Wexfor	_		l, Maryland	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra once.	11-	20a. Method of Disposition 20b. Place of Disposition (Namcometery, crematory or other state)		Date 1/12/2005	20c. Location - City o	
ij	t. Pag rtment rtant: I		`4 □Donation 5 □Other (Specify) WOOd Lawn Cemet	1			
Ba	permi Depa Impo any ir		Burgee-	-Henss-Sei alls Road	itz Funera Baltimor	1 Home, Inc e, MD 21211	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode stock, or heart failure. Ust only one cause on each line.	of dying, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
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	் _ ு வ்		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of d	elivery
.O. Box	death e atter	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown			Month	Day Year
<u>α</u>	law requires that the as been signed by the 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	ause given in Part I.		tobacco use contribute Yes 2 No 3	to the cause of death? Probably 4 Unknown
of Vital Records,	s been si should	Completed	11 redeasion		24a. Was	prior to	autopsy findings available completion of cause of
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Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 F No	Other -	of Death (Check only	one) idence 6 ☐Other (Sp	necify)
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sior	Attanding I or death. ector: After by the funer	catlo	2 Accident investigation M	1 Yes 2 N		(Street and Number or	Rural Route Number.
Division	if or Attane after death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide	, onice		wn, State)	
	To the Hospitel or At within 24 hours after of To the Funeral Direc completely filled in by	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.	at the time, date and in my opinion, deat	d place, and due to the h occurred at the time	e cause(s) and manner , date and place, and d	as stated. ue to the cause(s)
	To the within 2 To the comple	Me		License number	-	29d. Date signed (Mo	nth, Day, Year)
	1 1		Mayun Giw, mD	VEO5985-	>	Jan 13	2005
	0/10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	& Raver	1 Blvd,	Baltim	nth, Day, Year) , 2005 Lore 2/236
	St Regist	ate rar	31. Date (iled (Month, Day, Year) 32. Registrar's Signature	180	/		
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State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month Day Year Norman T. Chalk, Sr. **Physician** 9, 2005 January 8:00 A /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore** 3314 Paine Street | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Oct. 7, 1929 9. Birthplece (Stete or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral ₩**₩ 2□ F 75 217-24-8837 Vrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Healith and Mental Hygiene.
ansi: If Item 27 is marked other than "naturel", or Items 23a or 28a-1 ehow ansi: If Item 27 is marked other than "naturel", or Items 23a or 28a-1 ehow any or other traumatic event, its Medical Examinat must be notified at XXXX Yes 2 No MD N/A Baltimore 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number 3314 Paine Street 21211 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? XXXYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes XX No þ 3€XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Steel Products Elementary/Secondary (0-12) College (1-4or 5+) Assembly 10 18. Mother's Name (First, Middle, Maiden Sumame)
Margaret Kneesley 17. Father's Name (First, Middle, Last) Be Emory Elmer Chalk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Norman T. Chalk, Jr. (Son) 3314 Paine Street Balto, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Lorraine Park Cemetery 1/12/5 Woodlawn, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundial Service/Vicensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Small Cell hig Cancel Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 DEctopic pregnancy 1 Live birth in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Obs huch 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has I lirector, page 2 s autopsy performed 200 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DDA ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident I Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier uman 7703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) profressional Bldg, strar's Signature of Jane Johnston 32. Registrar's Signature 31. Date filed (Month, State Registra

State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 2. Date of Death 3 Time of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** January Conigland 11 2005 16:03 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore fUnder 1 Year | If Under 24 Hrs. Sinai Hospital 8. Date of Birth (Month, Day, Year) 02 24 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours 1 □ M 25 F ΜĎ Director 218-22-6645 87 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinat natural be indifficed at once. 10a. State 10h County 1 Yes 2 No Baltimore MD NA Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21216 U.S.A. 3622 Springdale Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black ۾ XXWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) House Homemaker 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Blanche Hicks James Dangerfield 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sylvia L. Sanders-Daughter 3622 Springdale Ave. Balt, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. 1/20/05 Owings Mills, 21. Signature/of Funeral Service Licenses 22. Name and Address of Facility MARCH FUNERAL HOME-WEST 4300 Wabash Avenue Baltimore, MD 21215 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Imprediate Cause (Final disease or condition Approximate Interval Between Onset and Death days ncumoma **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner use as the burial-transit death certificate be executed Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year detached for 5 Other (specify) ☐Yes 2 No Division of Vital Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 2 No 3 Probably 4 □Unknown peen estive 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 1 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, i Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatrent 2 DER/Outpatient 3□ DOA ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) anucvy 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) đ DMahony StPan 30 MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Darsie Cole 05-254 AKG

AK(-254 G		1 - For Unpend Item 2	State of M 3a&27 per	aryland/Depa me G841	artment of Heal -2-05 tas tificate of Dea	th and Mental Hy ath	giene 2005	01019				
	Physici /Medi		Decedent's Name (First, Middle, Last, DARS)		(OLE	2. Date of D Month Januar	Day Year	3. Time of Death 5:34 P M				
	Examir	ıer	4a. Facility Name (If not institution, give Washington County l			4b. City, Town, or Loca Hagerstown		4c. County of Dea Washing					
2568	Funeral Director		5. Social Security Number 6. Se 233 – 92 – 8633 15 Usual Residence of Decedent	7. Ag	43 Yrs. last birthday)		ours Min. 8. Date of B (Month, D	irth Pay, Year) 9. Bir C , 1961 WES	thplace (State or Foreign ountry) TVIRGINIA				
	Maryland -f show fied at	tor	10a. State 10b. County MD WASHING	GTON	10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 ☐ No				
	h with the 23a or 28e	al Director	10e. Street and Number 116 SOUTH LOCUST	STREET		10f. Zip Code 2174	10	10g. Citizen of What Co	ountry?				
036	urs after deal ei', or items	by Funeral	11. Marital Status 1 Never Married 2 X X Varried 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	No I	f Yes, specify Cuban, Me	ic Origin? (Specify Yes or N exican, Puerto Rican, etc.) ecify:	0- 14. Race - Am Black, Whi					
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. I Health and Mental Hygiene. It has not been 23a or 28e-f show other traumatic event, the Medical Exercitor must be rediffed at	Completed	15. Decedent's Edu (Specify only highest grad Etementary/Secondary (0-12)		(Give	dent's Usual Occupation kind of work done during DO NOT use retired) ING & HANDLING		16b. Kind of Business ROYCE HOIS MANUFAC	ERY				
/land	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than eny injury or other traumatic event, the Me once.	To Be C	17. Father's Name (First, Middle, Last) CHARLES EDWARD	ROBERTS		18. 1	Mother's Name <i>(First, Middle</i> CHRISTINE E	e, Maiden Sumame)					
	and 2 should ealth and Men n 27 is marke er traumatic		19a. Informant's Name/Relationship (T) ANITA JOHNSON/SI		116	SOUTH LOCUS	lumber or Rural Route Numb ST STREET, HA	GERSTOWN, M	D 21740				
Baltimore,	Pages 1 ment of Ho tent: if iter		20a. Method of Disposition 1 X Surial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	lemoval from State	20b. Place of Dispo cemetery, crer MT. HOPE	natory or other place)	JANUARY 15, 2005	20c. Location - City or	BURG, WV				
Balt	Departr Departr Importe eny inju		21. Signature of Funeral Service Licens Chaelis M	Biown	, , ,	27 W. KING SI.	FasiliX HOME, P.O. BOX 8 ,, MARTINSBURG, 1	WV 25402					
	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only of timmediate Cause (Final disease or condition resulting in death)	ne cause on each li	is of the ${ m L}$		ch as cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death				
	/Medical Examiner	_		Due to (or as a consequence of):									
8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	>.	a consequence of):								
P.O. Box 68	ne death certif the attending thed for use a	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ▼Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant a 9□ Unknown	2 Fetat death 3	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year				
ds, P	luires that the signed by ald be detacted	d by PI	Part II. Other significant conditions co.	ntributing to death b	out not resulting in the u	nderlying cause given in I		tobacco use contribute to	o the cause of death?				
Vital Records,	s icien : The law require certificate has been sis rector, page 2 should b	Completed					24a. Wa. auto perf 1 XYes	s an 24b. Were an prior to death? 2 \(\text{No} \) No 1 \(\text{No} \) No	utopsy findings available completion of cause of 2 No				
of Vita	Physicien: Th this certificate al director, pag	To Be	TIA THS 2 NO	lospital: 1 Inpatio		t 3 DOA Other: 4	Place of Death (Check only Nursing Home 5 Res	idence 6 Other (Spe	city)				
Division o	ng f fter	Certification;	27. Manner of Death 1 Natural	28a. Date of Inju (Month, Da 28e. Place of Injuding, et	ury - At home, farm, str c. (Specily)	Work? M 1 ☐ Yes	2 No	how injury occurred (Street and Number or River, State)	ural Route Number,				
Ω	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	ical Cer	29a. Certifier (Check only AM Medical Exami	sician: To the best	of my knowledge, death	occurred at the time, da	ite and place, and due to the	a cause(s) and manner as	s stated.				
	To the within 24	Medical	29b. Signature and title of certifie	and manner st	ated.	29c. License num O.C.M.E	nber	29d. Date signed (Mont January 14,	th, Day, Year)				
-			30. Name and address of person who co	GUN		Penn Street,	Baltimore, B	Maryland 21	1201				
•	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 9 2005	32. Registr	ar's Signature	to the second							

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23e or 28e-f show any injury or other treumatic event, It e Madical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For Unpend 1	Item :	State o 23a,27	, 28a f	and/Dep per me	artme rtifica	nt of te of	lealth Death	and l tas	Menta	l Hygiei Reg.	ne 0	05	01020)
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nin		4a. Facility Name (If not instit	ution, give	street and nu	mber)		4b. City	, Town, o	r Location	of Death	h		4c. Coun	ty of Deat	th	
_		Bon Secours He						ltimo	re	r 24 Hrs.	T 0 5	10:41		0.5:		
al		5. Social Security Number	6. Se	x ⊐M.2√∑]F		rs. last birthday Yrs.	Months	or 1 Year Days	Hours		(Moi	of Birth oth, Day, Ye		Co	thplace (State or Foreign ountry)	n
or	}	215-96-3700 Usual Residence of Deceden)	21	38	3				1	12	12	66		MD	
		10a. State 10b. Co			10c.	City, Town or I	ocation								10d. Inside City Limits	;
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	Director	10e. Street and Number					10f. Z	ip Code				10g.	Citizen of	f What Co	ountry?	
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	by Fu	XXNever Married 2		1 ☐ Yes If Yes, Gi	Ve		1 🗆 Yes	2 X No	Specify	y:			Spec	ify:	Black	
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	Be C	17. Father's Name (First, Mic	ddie, Last)					,,,,,		her's Nar	me (First,	Middle, Maid			<u> </u>	
	ToB	Lonnie J. C	larte	r					Seli	ina	Muse	a				
		19a. Informant's Name/Relat				19b. Mai	ling Addre	ss (Street				Number, Ci	ty or Town	n, State, 2	Zip Code)	
		Mr & Mrs Ca	rter	-Pare	nts	442	Ran	dom	Road	d, E		imore	, Mo	d 2	1229	
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremat	tion 3 🗆	Demoval from		 b. Place of Disposer cemetery, cr 	osition (Na ematory or	ame of other pla	ce)		Date	200	. Location	- City or	Town, State	
		4 Donation 5 Othe				it. Zi	on C	emet	ery	1/2	21/05	5 Ва	ltin	nore	, Md	
once.		21. Signature of Funeral Ser	vice Licen:	See al	1.		Marc	and Addre	ss of Faci	ility						
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an		Immediate Cause (Final disease or condition resulting in death)		a.Cocai	ne int	oxicati	on									
al er		resulting in death)		Due to	(or as a con	sequence of):										
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	an/N	1F FEMALE: 23b. Was decedent pregnan	11	23c. If yes, ou 1 ☐ Live	tcome of pre		□Ectopic	pregnanc	y					ate of del	livery Day Year	
	Completed by Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No			nant at time		Other (specify) _				-	19	NOTHI	Day Teal	
	Phy	9 Other significant	nditions of		looth hut not	requiting in the	undarhina		on in Par	• 1	236	Did tobac	n use co	ntribute to	the cause of death?	
	by	Part II. Other significant cor	HUILION'S CO	ontributing to c	eath but not	resulting in the	ungenying	cause gn	/BIT III Faii	i I.	250	1 ☐ Yes			6.0	า
	eted														- 1	
	ldm										248	a. Was an autopsy performed		prior to death?	utopsy findings available completion of cause of	9
	ပိ						-					Yes 2□	No	1 Yes	2 □ No	
	Be c	25. Was case referred to me examiner? 1 ¬Yes 2 □ No	-	Hospital:	Inpatient :	2 ▼ ER/Outpati	ent 3□ [Ott	200			k o <i>nly one)</i> □ Residence	6 🗆 0	ther (Sne	cifu)	_
	: To	27. Manner of Death		28a Date	of Injury	28h Time		28c. Inju		tursing i		scribe how i			unk	
	atlor		ending vestigation	Found 1-16-	nth, Day Yea 05	9:00	\mathbf{p}^{M}	1	Yes 2	X No						
	Hice	3 ☐ Suicide 6 🛣 C	ould not be etermined	28e. Plac	~~	At home, farm, s		ory, office			28f. Loc	ation (Stree	t and Nun	nber or Ru	ural Route Number, ntalou Stre	et
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	Medical Certification;	29a. Certifier 1 Cer (Check only 2 Med one)	tifying Ph	iner: On the b	e best of my pasis of exam nner stated.	knowledge, deanination and/or	ath occurre investigation	ed at the ti on, in my o	me, date a opinion, de	and place eath occu	e, and due urred at the	to the caus e time, date	e(s) and n and place	manner as e, and due	s stated. e to the cause(s)	
•	Me	29b. Signature and title of ce	ertifier				2	9c. Licens	se numbe	r		29d.	Date sign	ned (Monti	h, Day, Year)	
		Thede	M.	Line	(rus	2		OCI	Æ			Jan	uary	17,	2005	
				completed cal	e of death (Item 23a) (Type		Penn	Stre	et.	Balt	imore.	Mar	yland	d 21201	
Sta	te.	THE ODE RE M.		32.1	Registrar's S	ignature				,				-		
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Registrar

DHMH 17 Rev 1/2001

			1- State of Maryland		artment of H tificate of L			ene 00	5 01021
	• Physici		Decedent's Name (First, Middle, Last) VIRGIL		CREEL		2. Date of Death JANUARY	14, 200	3. Time of Death 6:35 P
	/Medio Examir		4a. Facility Name (If not institution, give street and number) 4216 FALLSTAFF ROAD		4b. City, Town, or	Location of Death	RE	4c. County of D	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia 1 M 2 F 50	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth MAY 13,	1954	Birthplace (State or Foreign Country)
	show		Usual Residence of Decedent 10a. State 10b. County 10c. City,	Town or Lo	cation				10d. Inside City Limits
	he Mar 28a-1 sl	Director	MD BALTIMORE 10e. Street and Number	BALT	I MORE		100	g. Citizen of Wha	1 Yes 2 No
	3a or	i Dir	4216 FALLSTAFF ROAD		Tot. Zip Gode	21215	10,	g. 01112011 01 11111a	USA
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Madical Examination was be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🛱 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, Vhite, etc. WHITE
2-00	72 hou natura	eted	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa	during most of work		6b. Kind of Busin	ess/Industry
21215-0036	filed within Hygiene. other than suf, the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		PHONE TEC	HNICIAN		TELEPHO	NE
Maryland	ould be filed with Mental Hygiene. arked other than atic evant, Ine M	To Be	17. Father's Name (First, Middle, Last) VIRGIL	CREE	L	MYRTLI	e (First, Middle, Ma	aiden Sumame)	ARTLIP
Mary	and 2 should balth and Men n 27 is marke ier traumatic		19a. Informant's Name/Relationship (Type, Print) LYNN CREEL / WIFE		ng Address (Street a				
ore,	Pages 1 ar nent of Hea int: If item 3 iry or other		20a. Method of Disposition 20b. Pla 1 Rurial 2 Micremation 3 Removal from State	metery, crer	sition (Name of matory or other place	Θ)		Oc. Location - City	
Baltimore,	permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other trau		4 □ Donation 5 □ Other (Specify) HILL 21. Signature of Funeral Service Licensee	22	Name and Address	s of Facility SO	LEVINSO		S., INC.
	207 29		23a. Part1. Enter the disease, or complications that caused the death.						Approximate
	Physician /Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Cuuslise to (or as a consequence)	wo	ud to		/3		Interval Between Onset and Death
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8760,	cate be executed physician and the burial-transit	dlcal Examiner	Cause Disease or Injury that initiated events resulting in death) Last C	ence of):					
Box 6	ne death certifi the attending hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
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ion of	Attending Phys ir death. ector: After this by the funeral di	ation; To	VE TOS 2 NO I I Inpatient 2 E	28b. Time of Injury	28c. Injun Work	/ at	28d. Describe how		Specify) SCENE Stylef
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	Suicide 6 Could not be determined 28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, str			28f. Location (Stre City or Town,	et and Number of State) 4216	Rural Route Number Pel.
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my know 2 Medical Exeminer: On the basis of examinati and manner stated.	vledge, death on and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and manne e and place, and	or as stated. due to the cause(s)
	To th To th Comp	Me	29b. Signature and title of vertifier		1	e number CME		d. Date signed (MANUARY 10	
10	713		30. Name and address of person who completed cause of death (Item		All	N STREET,	BALTIMOR	RE, MARY	LAND, 21201
J	Sta Registi		31. Date filed (Month, Day, Year) 32. Red strar's Signate	ште	parti				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 5 Certificate of Death Reg. No: t. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Ann Cannon 18 2005 /Medical anvary 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Stella Maris at Mercy Hospice
6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Yrs **Director** 213-34-6310 80 November 6 1924 Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 √Yes 2 No Maryland NA Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 1108 Dundalk Avenue 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ŏ 1 ☐ Yes 2 No Specify: by Specify: 3 □Widowed 4 □ Divorced White Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 8 Seamstress Tie Company Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Anton Jarmicki Marianna Cierzniak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra Michael Cannon (Son) 7934 Eastdale Road Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State January Sacred Heart of Mary ` 4 ☐ Donation 5 ☐ Other (Specify) 21 2005 Dundalk, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility W. Dabrowski/Chojnacki Funeral Homes P.A. NAC 1005 Dundalk Ave. Baltimore, Maryland 21224 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, see on each line. Approximate Interval Between Onset and Death astro Immediate Cause (Final **Physician** 0 (uncer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 ☐ Other (specify) 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2ENo the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Waspice Certification: To 1 Tes 21 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: , 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 Maltimor 32. Restrar's Signature 31. Date filed (Month, Day, Year) 9 2005 Registrar

Funeral Director

		-	1	Usual Residence of	Decedent	
		yland how		10a. State	10b. County	
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	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23s or 28s-f show any injury or other traumatic avent, I'm Medical Examinat must be recilied at ance.	To Be Completed by Funeral Director		15. Decedent's E cify only highest gi	ducationade co
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×	5. Social Secur 218-38-	ity Number	6 Sax		. Age (In yrs.) If Under Months	1 Year	f Under 24 Hrs Hours Min	s. 8. Date of	Birth Day, Yea	Ö/.1	9. Birth	place (State or For
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	Examir		4a. Facility Name (If not institution, S WY3 HWGO AOG VI	ive street and number)		4b. City, Town, o		Death	4c. County of Deal	
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23e or 28e-f show any injury or other traumatic event. The Medical Extending must be notified at anote.	Completed b	15. Decedent's (Specify only highest Elementary/Secondary (0-12) unk	Education	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most o	f working unk	16b. Kind of Business	Industry unk
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68760,	icate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					
P.O. Box 68	death certifi e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	☐ Fetal death 3 ☐	□Ectopic pregnanc □ Other (specify) _	у		23d. Date of del Month	ivery Day Year
	og og	by	Part II. Other significant condition		not resulting in the u	nderlying cause gi	ven in Part I.		obacco use contribute to res 2 □ No 3 □ Pr	~ /
Il Records,	The law ate has b page 2 s	Completed						24a. Was autop perfor 1 🗆 Yes	sy a prior to	utopsy findings available completion of cause of
Vital	Physiclan: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 → Ses 2 → No	Hospital:	2 XER/Outpatien	nt 3□ DOA Ot	har	Death (Check only o	ne) dence 6 □Other (Spe	cify)
ion of	ding After fune	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	Wid	ry at ork? Yes 2 No	Acian Ma	now injury occurred PDD QDCUS	
Division	T B C	Certification	3 Suicide 6 Could no 4 Homicide determin			reet, factory, office		28f. Location (5 City or Tou HATG	Street and Number or Ri vn, State) \$12 Co	ural Route Number,
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)	To the To the comp	Ň	29b. Signature and title of certifier	mo	(our)	29c. Licen	se number		29d. Date signed (Mont	
			30. Name and address of person with CARL I. MAR		ath (Item 23a) (Type, ILS Rockbill	Print (ICE) A	ogkville	MD 10857		
	Sta Registi		31. Date filed (Month Pay, Year)	2005 32. Fig istrar	's Signature	berli				

			State of Maryland / Department of Health	and Me		_	0 1-1	01005
			Registrar Certificate of Death			g. No U	J5	01025
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day	Year	3. Time of Death
	/Medic	al	Theodore W. Eschmann 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location	of Dooth	Januar	y 13, 2		4:05 A ^M
	Examin	er	Greater Baltimore Medical Center Towson			Balt	imor	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 G F 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Year Hours And 1 Months Days Hours	Min.	8. Date of Birth (Month, Day, APR 21,	^{Year)} 1934	9. Birthpla Count New	ace (State or Foreign try) York
	pur		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10	Od. Inside City Limits
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3	ter de Itami	-une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 1 □ Yes 2 □ YNO 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica	an, Puerto P	rity Yes or No- Rican, etc.)		- America , White, e	
036	ours aft	by	If Yes, Give 1 ☐ Yes 2 🕱 No Specify Year or Dates:	<i>/</i> :		Specify:	wh	ite
5 E	72 hours "natural",	etec	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired)	st of workin	9 1	6b. Kind of Bus	siness/Ind	ustry
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Theodore Maryland 21215-0036	d 2 should th and Mer 7 ie merke traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb Marge Eschmann - wife 26 Silverton Court				State, Zip (2103)	
Q .	s 1 and 2 f Health item 27 other tre		20a. Method of Disposition 20b. Place of Disposition (Name of			Oc. Location - C		
A 4	Page nent o ant: If ury or		11 Bunal 2 Dicremation 31 Bernoval from State 1	01/18	3/05 B	eltsvil	.le,	MD
Eschman	permit. Pages 1 an Department of Heal Importent: If Item 2 eny injury or other ance.		21. Signature of Funeral Service Licensee MO0986 And Address of Fact Rephen I 8717 Green Fast	D. Loh	rmann,	PA Towson	MD	21286
- L	581198		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.				LIL	Approximate Interval Between
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000	law re las be	Completed			24a. Was an autopsy	24b. W	ere autop	sy findings available
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Division of Vital Becords P.O.	or Att	Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	8f. Location (Stre City or Town,	eet and Numbe State)	r or Rurai	Route Number,
-	To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the		29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, determined to the basis of examination and/or investigation, in my opinion, determined to the basis of examination and/or investigation, in my opinion, determined to the basis of examination and/or investigation, in my opinion, determined to the basis of examination and/or investigation, in my opinion, determined to the basis of examination and/or investigation, in my opinion, determined to the basis of examination and/or investigation, in my opinion, determined to the basis of examination and/or investigation, in my opinion, determined to the basis of examination and/or investigation, in my opinion, determined to the basis of examination and/or investigation, in my opinion, determined to the basis of examination and/or investigation, in my opinion, determined to the basis of examination and/or investigation, in my opinion, determined to the basis of examination and/or investigation, in my opinion, determined to the basis of examination and/or investigation, in my opinion, determined to the basis of examination and/or investigation, in my opinion, determined to the basis of examination and/or investigation and the basis of examination and opinion	and place, as	nd due to the cau	use(s) and man	ner as sta	ited.
	thin 24 thin 24 the F mplete	Medical	one) and manner stated. 29b. Signature and the of certifier / 29c. License number			d. Date, signed		
	F 3 F 8		· Pal ('Daw, mo D30)	529		1/13	120	125
	15		30 Jame and address of person who completed cause of death (Item 23a) (Type, Print)	T B	ATMA	no no) 2	1205
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	17,700	111		
	Registr	ar	JAN 1 9 2005 Malue & Boards					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem#105 c. 14 per FII 6840.28705 TI State of Maryland 7 Department of Health and Mental Hygiene 2000 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 11.54 AM **Physician** 2005 Eaddy LAMUHRY Michael 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** N/A BALTIMORE GOOD SAMARITAN HOSPITAL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Min **Funeral** Months Days Hours XXM 2□ F 213-94-8063 Yrs. 1963 Germany 16 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Examinar crust be notified at Baltimore Parkville 1 Yes 2 □ No MD Director Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō USA 21234 or Items 23a 7515 Hillsway Avenue Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Black 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 þ White 3 Widowed 4 Divorced "natural" 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PTC Training School Instructor N/A and Mental Hygier Is marked other th 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joyce Hurst Jathan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7515 Hillsway Avenue Baltimore, MD Joyce Eaddy-mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Department of Important: If It any injury or conce. Co. MD Baltimore 1/18/2005 Oaklawn Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MARCH FUNERAL HOME-EAST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21202 1101 E. North Avenue Baltimore, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) AUREUS EMBOCARDITIS STAPHYLOCOECUS Pnysician /Medical Due to (or as a consequence of): ARSCESS **Examiner** AMMULUS WITH Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Box 68760, sician as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery ed by the attendin detached for use 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) P.0 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BACTERIAL HISTORY OF EMBOCHADITIS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 No Yes 2 No 1 Yes of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After the funeral of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: Injury Division To the Hospital or Attending 1 Natural 2 Accident 5 Pending 1 Yes 2 No investigation within 24 hours after death To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier RES OOD 2005 JAMUARY 12, Jumator, MYONATOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAJERA BOULEVARD MD 21239 SAMARITAM HOSPITAL, 5601 HOCH 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MICHAE

GARY FULLERTON 05-00228 RKD

			me (First, Middle, Las						2. Date of Deat	th		3. Time of Death
Physic /Med		GARY	LUKE FU	LLERTON					JANUARY	8',	2005 ^{ear}	5:22P.
Exam		4a. Facility Name SINAI HO	(If not institution, give SPITAL	street and number)			y, Town, or Location	n of Death		4c. (County of Deat	h
Funera Directo		5. Social Security 195–40–6	086	7. Age	(In yrs. last birth Y	nday) if Und Months		er 24 Hrs. Min.	8. Date of Birth (Month, Day 2/28/19	Year) 48	9. Birtl Co Pen	hplace (State or Fore untry) nsylvania
land		Usual Residence 10a. State	10b. County		10c. City, Town	or Location						10d. Inside City Limi
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3a or 2		10e. Street and N	umber Lyview Dri	ve		10f. 2	Zip Code 21078		1	10g. Citiz	en of What Co	ountry?
death	Funeral	11. Marital Status		12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Dec	edent of Hispanic (becify Cuban, Mexic	Origin? (Spe	ecify Yes or No-	1	4. Race - Ame Black, White	
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Pages 1 and 2 nent of Health int: If item 27 iny or other tree		20a. Method of D	2 Cremation 3 C	Removal from State		y, crematory of	lame of r other place) Cemetery				ation - City or	Town, State
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	Exami	ner	4a. Facility Name (If not institution,				4b. City,	Town, or	Location of	of Death			County of De		
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	Funeral			5. Sex 7. Ag 1 ☐ M 21公 F		ast birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Birt (Month, Day April	h V. Year)	9. B	rthplace (Sountry)	State or Foreign
	Director		217-18-2993 Usual Residence of Decedent	- 4	80	115.					April 3	3, I	924 Ma	iry1aı	na
	land ow		10a. State 10b. County		10c. City	Town or Lo	cation							10d. Ins	ide City Limits
	Mary f sh	ţō	Maryland Balt:	imore	Lant	thervi	116							10]Yes 2∑No
	1 the	rec	10e. Street and Number			CIICLVI	10f. Zip	Code				10g. Citi	zen of What (country?	
	death with the Maryland rms 23a or 28e-f show f must be notified at	Ö	229 E. Ridgely	Road				210	a3				U.S.A		
	ms 2	Jera	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. Y	Nas Dece			gin? (Spe	cify Yes or No- Rican, etc.)	. [14. Race - An	erican Indi	ian,
9	after or ite	by Funeral Director	1 X Never Married 2 ☐ Marrie	Armed Forces? d 1 ☐ Yes 2 💆 If Yes, Give		1					Rican, etc.)		Black, Wh	ite, etc.	
93	ral',	db	3 Widowed 4 Divorced	Year or Dates:			1 🗆 Yes	Z JAŽI MO	Specify:				Specify: W	hite	
21215-0036	72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)		16a. Deced	kind of wo	rk done a	luring mos	t of workir	ng	16b. Ki	nd of Busines	s/Industry	
121	Mithin han	mpi	Elementary/Secondary (0-12)	College (1-4or s	5+)		DO NOT u:					TT		. 1	
	lled v tygie her t		17. Father's Name (First, Middle, Li	4 years		Manag	ement	Ass					ing Au	thori	.ty
anc	12 should be filed within ? h and Mental Hygiene. 7 le marked other than " reumetic event, It a Med	Be									(First, Middle,	_	Sumame)		
Ž	d Me d Me nark netic	2	Luther Fram			10h Mailia	- 4	/C4 4 -	Dais			aul	- T C4-4-	7:- 0- 4-1	
Maryland	d 2 si th an 7 te r		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City Mary Christis (sister) 229 E. Ridgely Road Lutherville												
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importance of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23s or 28e-f show any injury or other treumetic event, it a Medical Examinar must be notified at once.		20a. Method of Disposition	(SISCEL)	20b. Pla	ace of Dispo	sition (Nar	ne of			ate		cation - City of		
Baltimore,	nt of nt of :: If it		1 🔀 Burial 2 □ Cremation 3		ce	metery, crer	natory or o	ther place	· 1						
Ħ	rtane ritem		 4 □ Donation 5 □ Other (Special Service Line) 21. Signature of Funeral Service Line 		Dru	id Ric						Pike	esville	e, Mai	ryland
Ba	permi Depa Impo any ir		21. Signature of Pulleral Service Li	Cellsee		M	itche	11-W	iedef	eld :	Funeral 1timore	Hor	ne, Ind	·	24.0
			23a. Part1. Enter the disease, or c	omplications that caused	the death	Do not est	0500	York	Road	l Ba	<u> Itimore</u>	e, Ma	aryland		212 eximate
			snock, or neart failure. List o	nly one cause on each li	ne.	DO HOL BIIL	51 trie (1100	e or ayırı	y, sucii as	cardiac of	i iespiiatory ar	1051,		Interv	al Between t and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 901	515									DI	273
	Examiner		,	Due to (or as	a conseque	ence of):	DA		•					1	· **
		<u></u>	Sequentially list conditions,	b. Due lo (or as	a nseque	ence of):	0: 12	200						Cocci	n(org
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	DA	arm	/	Nec	1:1	2/5					1/1-	270
	axecu al-tra	xai	that initiated events resulting in death) Last	c. Due to (or as	a conseque									7	~v _>
8760,	sate be executed hysician and the burial-transit	dicai E		W.											
687		edic		0.											
Вох	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome									23d. Date of d	eliverv	
	death atte	ciai	in the past 12 ponths?	1 □Live birth 4□Pregnant at			Ectopic pr Other (sp						Month	Day	Year
P.O.	the cy the	ys	9 Unknown	9□ Unknown											
	The law requires that the death certific sie has been signed by the attending p page 2 should be detached for use as	by PI	Part II. Other significant condition	s contributing to death b	ut not resul	lting in the u	nderlying c	ause give	en in Part I.		23e. Did to	bacco u	se contribute	to the caus	se of death?
rds	n sig	d b									1 🗆 Y	'es 2[]No 3□	Probably	4 Onknown
00	w requir s been si should	Completed									24a. Was	 an	24b. Were	autopsy fine	dings available
Be	The law cate has page 2:	ЩC									autop	rmad?	death	,	dings available in of cause of
of Vital Records,		o l	25. Was case referred to medical						26 Place	of Death	1 ☐ Yes	2 No	1 UY6	s 2 N	0
>		To B	examiner? 1 ☐ Yes 2 X No	Hospital:	ent 2 🗆 F	R/Outpatien	t 3□ DC	Othe			ne 5 Resid		ther (Sp	aciful . «	
ō	g Phys er this eral dii		27. Manner of Death	28a. Date of Inju	ry 2	28b. Time of		8c. Injury	at		8d. Describe h		AND DESCRIPTION OF THE PARTY OF	GCHy) O	JA ICE
ion	nding I nth. :: After e funer	atio	1 Accident 5 Pending 2 Accident investiga	(Month, Daj	y Year)	Injury	М	Work 1 □ \	:? /es 2 🔲 I	No					
Division	l or Attendi efter death. Director: A	Certification:	3 Suicide 6 Could no 4 ☐ Homicide determin	t be ed 28e. Place of Inju	ury - At hon	ne, farm, str	et, factory	, office		2	8f. Location (S			Rural Route	Number,
Ö	s efte	Sert	4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street City or Town, Sta)		
	To the Hospitel or Attending Phymitin 24 hours eliter death. To the Funerel Director: After the completely filled in by the funeral													as stated.	
	n 24 n 24 ne Fu	edic	29a. Certifier Check on the Control of the Dest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner of the cause of										place, and d	ue to the ca	tuse(s)
	To the To the comp	Σ												nth, Day, Y	ear)
	T LANGE		XVIV a	M	S			NO	583	503		jan	vary 1	4 200	25
	4		30. Name and address of person w	no completed cause of d	eath (Item :	23a) (Type,	Print)	ſ			21.		1	3 /	10.1
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMON CHARLES MD 6601 N Charles ST Salts more Ma										5	coy	
	Sta	ıtę	31. Date filed (Month, Day, Year)	a 20032. Regist	r's Signatu	ire &	Lore	E)							
	Registr	ar	JAN I												

1/13/2005 @ 4:15 Pm.

Trampton, Lucille

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 11:10 a M Emma Elizabeth Fertitta 2005 10 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore n/a Mercy Hospice 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea July 21 1 Birthplace (State or Foreign Country) 5. Social Security Number Unk 6. Sex **Funeral** Min Months Days Hours 1 M 2 XF Yrs 1923 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ans: If item 27 is marked other than "natural; or iteme 23a or 28a-f show usy or other than the result is the mortilled at ury or other traumatic event, its Medical Examinat must be notified at 1 X Yes 2 ☐ No Baltimore Funeral Director Maryland n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21223 1307 W. Cross Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married ertitle Emma White 1 ☐ Yes 2 ☑ No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Seamstress 18. Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) unk Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rose Acton / Daughter 1208 Glyndon Avenue, Baltimore, Maryland 21223 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of h important: if ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 1/14/2005 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cuny resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of high part that initiated events Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Box 68760. ettending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, Colon 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 XOther (Specify) Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Peath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after deat 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ò 4 Thomicide filled in within 24 hours a Medical 29a. Certifies Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier 40854 10/2005

DHMH 17 Rev 1/2001

State Registra

301

agistrar's Signature

ST Paul Pl Ballimore

mel.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Riseber

2005

32.

31. Date filed (Month, Day, Year)

			1 icasc	State of Ma		artment of Health		-		
			1 - For State Registrar	Otate or ma		tificate of Deat			2005	01030
			Decedent's Name (First, Middle, La	st)	- 1		2.	Date of Death		3. Time of Death
	Physici /Medio		Mary Lo	UISE_	toster		J	Month ANUAIZY	Day Year	3:15 AM
	Examir		4a. Facility Name (not institution, give	street and number)		4b. City, Town, or Location			4c. County of Death)
	25		GOOD SAMARI			BALTIN If Under 1 Year If Under		Date of Birth	N/A	- (0)
	Funeral Director		5. Social Security Number 6. S	M 2XF 7. Age	(In yrs. last birthday) Yrs.	Months Days Hours	s Min.	Date of Birth (Month, Day, Y	ISTITUTE I	place (State or Foreign
			Usual Residence of Decedent				i j	une a	,1145 (Vor	in Calulina
	show		10a. State 10b. County	1	10c. City, Town or Lo	cation				10d. Inside City Limits 1 X Yes 2 No
	8e-1	Director	Maryland N/	4	Balti	more		40.	000	
	with ti		10e. Street and Number	0+		10f. Zip Code		100	g. Citizen of What Co	
)	ns 23	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S. 13.	Was Decedent of Hispanic Of Yes, specify Cuban, Mexic	Origin? (Specif	y Yes or No-	14. Race - Ame	
9	or Iter	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 M No If Yes, Give	0	if Yes, specify Cuban, Mexic 1 □ Yes 2 ☑ No <i>Speci</i> i		can, etc.)	Black, White	o, etc.
93	ural', c	d by	3 Widowed 4 □ Divorced	Year or Dates:		/-			Specify:	ack
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28e-1 show ther, I're Medical Examinar must be neitified at	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(Give	dent's Usual Occupation kind of work done during m DO NOT use retired)	ost of working	16	6b. Kind of Business/I	ndustry
212	filed withi Hygiene. ther than ant, It e M	dwo	Elementary/Secondary (0-12)	College (1-4or 5-	F) /	se's As	Sista	int	Medi	cal
	illed I Hyg other	Be C	17. Father's Name (First, Middle, Last) (1:	1		ther's Name (F	irst, Middle, Ma	aiden Sumame)	
/lar	should be nd Mental marked o	ToE	Woodrow	Stew	art		Mary	Ha	ger	
Maryland	2 sho and is me		19a. Informant's Name/Relationship	Type, Print) (Broth	ker) 19b. Mailir	ng Address (Street and Num	mber or Rural F	Route Number, (City or Town, State, Z	ip Code)
_	1 and Health em 27 ther tr		20a. Method of Disposition	Loope	20b. Place of Dispo	sition (Name of	CTI	Dalte	Oc. Location - City or	Town, State
Baltimore,	/0 O		1 Burial 2 ☐ Cremation 3 [Cometery, crei	matory or other place)	1/20/2	-	a - c de	ulas MJ
II.	permit. Pages Department of Importent; if i any injury or once.		'4 Donation 5 Other (Special Signature of Funeral Service pice		11111, 210	Name and Address of Fac			ansoo	wne, ma
Ba	permit. Depart Import any inj		baseph	L KI	11/1/3	Seph L. Ru	SS Fy	riegal	Hame 2121	6
			23a. Parvi Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each line	the death. Do not ent	er the mode of dying, such	as cardiac or r	espiratory arres	t,	Approximate Interval Between
1	Fnysician		Immediate Cause (Final disease or condition	SEF						Onset and Death
1	/Medical Examiner		resulting in death)	, a	consequence of):					
В	LXuiiiiici	<u></u>	Sequentially list conditions,	b. Due to (or as a	consequence of):					
	nted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		, , , , , , , , , , , , , , , , , , , ,					
Ć	te be executed ysician and ne burial-transit	Exa	resulting in death) Last	Due to (or as a	consequence of):					
094	÷ × e	icai	•	d						
68 ×	death certifica e attending ph d for use as th	Med	IF FEMALE:							
Box	ath ce	ian/	23b. Was decedent pregnant in the past 12 mopths?	23c. If yes, outcome of	2 Fetal death 3	Ectopic pregnancy			23d. Date of deli Month	very Day Year
P.O.	00	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time of death 5L	Other (specify)				
	Physicien: The law requires that the this certificate has been signed by the rail director, page 2 should be detached.		Part II. Other significant conditions	contributing to death bu	it not resulting in the u	nderlying cause given in Par	urt I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	quires in sign	Completed by	End stage	Renal I	i sease			1 🗌 Yes	2 ☑ No 3 □ Pro	obably 4 Unknown
900	aw requir is been si 2 should	piet	Cirrhosis.					24a. Was an autopsy	24b. Were au	topsy findings available ompletion of cause of
H.	sicien: The lav certificate has rector, page 2 (mo						performe	ed? death? ⊒No 1 ☐ Yes	
Vital	ysicien: is certific director,	Be (25. Was case referred to medical examiner?					Check only one)	The second secon	
of \	hysio this c	2	1 ☐ Yes 2 ☑ No		nt 2 ER/Outpatier	nt 3 DOA Other: 4			ce 6 □Other (Spec	ufy)
nc)	ding Phy h. After thi funeral	tion:	27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day	y 28b. Time o (Year) Injury	f 28c. Injury at Work? M 1 \sum Yes 2		d. Describe now	injury occurred	
Division	r Attencer death	fica	3 ☐ Suicide 6 ☐ Could not I	28e. Place of Inju	ry - At home, farm, str				et and Number or Ru	ral Route Number,
Ö	el or / s after il Dire	Certification;	4 Homicide	building, etc.	(Specity)			City or Town,	State)	
(2)	To the Hospitel or Attending within 24 hours atter death. To the Funerel Director: After completely filled in by the funer	edical (29a. Certifier 1 Certifying P	nysician: To the best o	if my knowledge, deat	h occurred at the time, date vestigation, in my opinion, d	and place, and	d due to the cau	se(s) and manner as	stated.
	the H Din 24 the F	Medi	one)	and manner stal	ted.					``
N.	To To	Σ	29b. Signature and title of certifier	- MD		29c. License numbe			d. Date signed (Month	
7			30. Name and address of person who		ath /Itom 22a) /T	-			ANUARY 1	
				completed cause of de	LOCK Raw	Print) - BIUD BA	ALTIMOR	28, 17	D 2123	9
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registra	r's Signature			11-		
	Regist	ar	DIN TAN	JU3 / 1982 200	a Alla Allah	10.00				

DHMH 17 Rev 1/2001

MARY

FOSTER,

			For State Registrar		Maryland / Do		t of H	lealth a		ntal Hyg	•	0.5	01031
			Decedent's Name (First, Middle, La	st)					2	. Date of Dea	ıth		3. Time of Death
	Physici			Sara L	.ee Fornari	o				Month	Day Iary 10, 20	Year	11:45 p. M
	/Medic Examin		4a. Facility Name (If not institution, giv				Town, or	Location of	f Death	Jane	4c. Count		1
	_xamm		Gild	hrist Hospic	e Center				Baltim	nore		Baltim	ore City
. 6	Funeral		5. Social Security Number 6. S	ex / 7.	Age (In yrs. last birth	day) If Under		If Under 2) Voarl		place (State or Foreign ntry)
SAR	Director		206-26-7469	□M 2 X F	72 Yr	s. Months	Days	Hours					
~ ~	p ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location			36	eptember	7, 1932		Maryland
25	sho	٦	Toa. State Tob. County		Too. Oity, rowing	or Eucation							10d. Inside City Limits 1 ☐ Yes 2 No
1-10-050	Ne N	Director	Maryland Ho 10e. Street and Number	oward		10f. Zip		licott City	<u>y</u>		10- 011	145 1 0	
10	a or					10i. Zip	Code	2104	42		10g. Citizen of		
-	eath	by Funeral	2960 Normandy Dr.	12. Was Decede	ent Ever in U.S.	13 Was Decer	dent of Hi			fv Yes or No-	14 Bac	U.S	can Indian,
د)رج	r Iten	Fun	1 ☐ Never Married 2 Married	Armed Force	N No	13. Was Deced If Yes, spec	.1	n, Mexican,	Puerto Ri	can, etc.)	Bla	ck, White,	
65 € (C. 1215-0036	d within 72 hours atter death with the Maryland jiene. r than "naturel", or Iteme 23a or 28e-f show the Madical Evanilher must be notified at		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	7	1 🗆 Yes	2€ No	Specify:			Specif	y:	White
2 c	72 ho	Completed	15. Decedent's E (Specify only highest gra	ducation	16a. D	ecedent's Usua	al Occupa	ation	of working		16b. Kind of B	usiness/ir	dustry
3 2	thin	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	Give kind of wo ife. DO NOT us	se retired	i)	or working			Educ	ation
V) N	filed w Hygier Sther th	S		5+			Schoo	ol Teach					
on o	d tail	Be	17. Father's Name (First, Middle, Last,					18. Mother	r's Name (/	First, Middle,	Maiden Sumar	ne)	
yla	should be filed ind Mental Hygi i marked other umatic event,	은		I G. Miller	- 10. 1		/21				aline Ran		
ณกาง Maryland	S 20 20 20		19a. Informant's Name/Relationship ((ype, Print)	196. K	Mailing Address						State, Zij	Code)
	1 and Health		Mr. Nicholas Fornario 20a. Method of Disposition) Hust	20b. Place of D			ly Dr. Ell	licott Ci Dat		and 21043 20c. Location	City or T	own State
Forn Baltimore,			1 Burial 2 □ Cremation 3 □		cometen	crematory or o	ther place	e) !		4			
ا الله	permit. Pages Department of Importent: If i eny injury or once.		*4 ☐ Denation 5 ☐ Other (Specification 21. Signature of Funeral Service Like		Sti	nger Hill C	emete	ery		/2005	Ft. Lou	idon, P	ennsylvania
Ba	permit. Departn Importe eny inju		KAG IIII A		252					Δ			
			23a. Fart1. Enter the disease, or com	plications that cau	sed the death. Do no	t enter the mod	871 O	ld Colun	nbia Pik	e Ellicott	City, MD 2	21043	Approximate
	- THE WAY		shock, or heart failure. List only Immediate Cause (Final	one cause on eac	an line.			3,					Interval Between Onset and Death
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	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	c									
760,	s be executed sician and burial-transit		resulting in death) Last	Due to (or	as a consequence of)	:							
876	ate b	lical		d									
Вох 68	eath certiticat attending phy I for use as th	Mec	IF FEMALE:	00- 16									
Bo	attend for us	lan	23b. Was decedent pregnant in the past 12 months?		h 2 Fetal death	3 ☐Ectopic pr						te of deliv inth	ery Day Year
P.O.	that the de ed by the detached	yslc	1 ☐ Yes 2 No 9 ☐ Unknown	9☐ Unknow	at at time of death n	5 Other (sp	өспу)						
مَ	that the od by detact	by Physician/Med	Part II. Other significant conditions of	ontributing to deat	th but not resulting in the	ne underlying c	au <i>s</i> e give	en in Part I.		23e. Did to	bacco use cont	ribute to t	he cause of death?
sp	luires n signe ald be									1 Y	es 2 🗆 No	3 ☐ Prot	pably 4 Dunknown
000	w requir s been si should	lete								24a. Was a	n 24b.	Were auto	psy findings available
Be	The tav ate has page 2	Completed								autops	med?	d <u>ea</u> th?	mpletion of cause of
Ital	ien: Th rtiticate tor, pag	a	25. Was case referred to medical					26. Place	of Death /	1 Yes :		1 ∐ Yes	2□ No
>	nysicionis cert	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inp	atient 2 ER/Outp	atient 3 DC	A Othe	000		5 Reside		er (Specif	y Hospice
0 1	ding Ph h. After th tuneral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of I	Injury 28b. Tin Day Year) 28b. Tin	ne of 2	8c. Injury Work	at	280	d. Describe ho	ow injury occur	red	,
<u>s</u>	Attendin death. ctor: Aft y the tur	catl	2 Accident investigation 3 Suicide 6 Could not b			М	1 🗆 \	Yes 2 □ N	lo				
Division of Vital Records,	I or Att after d Direct I in by t	Certification:	4 Homicide determined	286. Place of	Injury - At home, farm , etc. <i>(Specify)</i>	i, street, factory	r, office		281	Location (St City or Town		er or Rura	al Route Number,
u	spitel		29a. Certifier 1 Certifying Ph	vsician: To the he	est of my knowledge, o	leath occurred	at the tim	e date and	Inlace and	due to the c	ausa(s) and ma	nnor as s	tated
(a .m	To the Hospitel or Attending Physicien: The law requires that the death certiticate be executed within 42 hours after death. To the Funerical pirector, their this certiticate has been signed by the attending physician and completely tilled in by the tuneral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Exar	niner: On the basi and manner	is of examination and/	or investigation,	, in my op	pinion, death	occurred	at the time, d	ate and place,	and due to	the cause(s)
TE	To tl withii To th comp	ž	29b. Signature and little of certifier	1/5	0			number		2	9d. Date signe	d (Month,	Day, Year)
			1/ Buth	my 1h	Ky, ml) /	12	5 207	•		MUM	1911	12005
			30. Name and address of person who	completed cause	death (Item 23a) (Ty	/pe, Print)	1	0	CL	Ba	BL	Mr.	2005 2120x
	Sta	to	31. Date filed (Month, Day, Year)	32. Reg	IX 67			- The second	دي مارا ،		-10 //		1 -0/0
	Registr		JAN	9 2003	istrar Signature	9							

			For ANTE	an toun		•	•	irtment of H	Health and I	Mental Hy	21111	5	01032
			Registrar APIP 1. Decedent's Name			k Phi Go	139 WEI	SI/COLCUM	Dealii	2. Date of De	neg. 140."		3. Time of Death
	Physici	an	Carol			lavaris				Month Januar	Day	Yeer	12:42P ^M
	/Media		4e, Facility Name (If					4b. City, Town, o	or Location of Deat		4c. County o		12:421
	Examir	ier	10601 Top			,			cevsville		Ralt	imor	
	Funeral		5. Social Security Nu		Sex	7. Age (In yrs.	ast birthday)	If Under 1 Year	If Under 24 Hrs	. 8. Date of Bir			lace (State or Foreign try)
	Director		215-32-686	6	1 □ M 2 🛱 F	7	71 Yrs.	Months Days	Hours Min.		22,1933		ryland
	D .		Usual Residence of I			10.00							Od Jasida Oita Linita
	arylar show	-	10a. State	10b. County		10c. Cit	, Town or Lo	cation					0d. Inside City Limits 1 ☐ Yes 2 🖾 No
)	88a-f	Director	MD		timore	Cc	ckeyst				40- 00:		
Z	vith th	Dire	10e. Street and Num					10f. Zip Code			10g. Citizen of WI	nat Coun	ntry ?
7	death with the Maryland ms 23a or 28a-f show Livest be notified at	ral		arren Ro		edent Ever in U.	Q 12 1	2103	30 Hispanic Origin? (S	Specify Ves or No	USA 14 Bace	- Americ	an Indian,
79	er de	Funeral	11. Marital Status 1 □ Never Marrie	nd 2 Married	Armed F		J. 13.	Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)		, White, e	
7, 7	ars af	by F	3 X Widowed 4		If Yes, G Year or I	ive		I ☐ Yes 2 ☒ No	Specify:		Specify:	Whi	Lte
() () () () () () () () () ()	2 hou	ted		15. Decedent's E			16a. Deced	lent's Usual Occup	pation during most of wo	rkina	16b. Kind of Bus	iness/Inc	dustry
012	Fig. 9	Completed	(Specili Elementary/Secon	fy only highest gr ndary (0-12)		(1-4or 5+)	life. I	DO NOT use retire	ed)	iking			
3 2	e the	Con	NIKO				UNK				UNK.		
, E	Mark Hard	Be (17. Father's Name (F	First, Middle, Las	t)				18. Mother's Na	me (First, Middle	, Maiden Sumame)	
W =	Meni darka	ပို	Roland T							Agnes 1			
0	2 sh and is m		19a. Informant's Na								er, City or Town, S		
F	and land lealth im 27 im		Alysa R.		/Daught	er 20h F		Topsfie sition (Name of	eld Dr.	Cockeys	ville, MD 20c. Location - C		
114/08	in it of the state		1 X Burial 2	Cremation 3 [State St.	emetery, crer Demet	natory or other pla	Janu	ary 17,		•	
1/14/0S	it. Partmer rtent		* 4 □Donation 21. Signature of Fur		7117		etery	. Name and Addre		005	Baltim	ore,	MD
a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturet", or items 23a or 28a-f show eny injury or other traumatic event, the Madical Examination unit be notified at once.		Dy	Will Br	000%	Clary	Le	mmon Fur	neral Hom	e of Du	laney Val	ley,	Inc.
			23a. Part1. Enter th shock, or hear	e disease, or con	nplications that	caused the deat	h. Do not ent	er the mode of dy	ing, such as cardia	c or respiratory a	irrest,		Approximate Interval Between
	Physician		Immediate Cause (F	Final					TATI AT				Onset and Death
	/Medical		resulting in death)	•	_ d	(or as a conseq							1 90
	Examiner		Sequentially list con	nditions.	b								
	D #	ner	Sequentially list con if any, leading to im- cause. Enter Under	mediate rlying	Due to	o (or as a conseq	uence of):						
	be executed ician and burial-transit	Examiner	Cause (Disease or in that initiated events resulting in death) L		c	o (or as a conseq	neuce of).						
0226	ate be executed thysician and the burial-transit	a		l.		(0. 40 4 00004	20.100 01,1						
29.7	physicate sthe l	dical			d						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	death certific	Physician/Me	IF FEMALE: 23b. Was decedent	pregnant		utcome of pregna					23d. Date	of delive	эгу
5	death a atter	clar	in the past 12 r	months?	4□Preg	birth 2 Feta mant at time of d		Ectopic pregnand Other (specify) _	у		Mon	th	Day Year
2	that the ed by the detached	hys	9 Unknown		9□ Unk	nown							
N GLAVAC	s tha	by P	Part II. Other signifi	cant conditions	contributing to	death but not res	ulting in the u	nderlying cause gi	iven in Part I.		tobacco use contri		
4	requires	ed								1	yes 2□No	3 Prob	pably 4 Unknown
7 5	law re as bee	Completed								24a. Wa	s an 24b. W		psy findings available mpletion of cause of
	The The ste had page	E O								perf 1 ☐ Yes	ormed?_ de	eath? □ Yes	2 No
- +	ien: artifica ctor,	Be C	25. Was case referr examiner?	ed to medical				T-		eath (Check only	one)		DAUGHTER"s
\leq	Physicien: This certific ral director,	2	1 Yes 2				ER/Outpatier	I 3 DOA		Home 5 Res			Residence
2	ing P	on:	27. Manner of Death	5 Pending	(Mo	e of Injury onth, Day Year)	28b. Time o Injury	Wo		28d. Describe	how injury occurre	,a	
07 :	tend death tor: /	cat	2 ☐ Accident 3 ☐ Suicide	investigati 6 Could not	ho -	a of loises. At h	omo form et	M 1 C	Yes 2 No	28f Location	(Street and Numbe	r or Bura	al Route Number
PROLYN GLAVAR	lor Attending after death. Director: After in by the fune	Certification:	4 Homicide	determine	d 20e. Flac	ding, etc. (Special	y)	eer, ractory, onice	,	City or To	own, State)		
0	pours sours and filled		29a. Certifier	Cartifying [Physician: To the	ne best of my kno	wledge, deat	h occurred at the t	time, date and place	ce, and due to the	cause(s) and mar	iner as s	tated.
	To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending peompletely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one)	2 ☐ Medical Ex	aminer: On the	basis of examina inner stated.	ition and/or in	vestigation, in my	opinion, death occ	curred at the time	, date and place, a	nd due to	o the cause(s)
	To th Within To th compl	13/	29b. Signature and	title of certifier	1			29c. Licen	se number		29d Date signed	(Month,	Day, Year)
	210		16	,IW	1			\mathcal{D}	27730	?	JAN 1	4, 2	1005
_	12		30. Name and addre		o completed ca	use of death (Iter	n 23a) (Type,	Print)	IT. 6	A Tras	JAN 1	2/1	204
	10		31. Date filed (Mont	COVIEN Year)	7/7	■glstrar's Sign	ature .	マレしじ			1	-/-	
	St Regist	ate rar		AN 1 9 2	1.2	and a digiti	18 A	and I					
			9	THE TO C	UUJ	The state of the s	No. of the same	10000					

DHMH 17 Rev 1/2001

ORIGINAL

Registrar DHMH 17 Rev 1/2001

State

Greene, Willard 1-12-05 065

			For	State	of Marylar				d Mental H	ygiene	0.00	0.1001
		_1	- State Registrar			Cei	rtificate of	Death		Reg. No. U	U5	01034
	Physicia	n	. Decedent's Name (First, Middle						2. Date of D Month	Day	Year	3. Time of Death
	/Medica	al -	ANITA OKO				4h Cib. Taura	al antine of B	Janua		2005	6:58pm M
	Examine	r	a. Facility Name (If not institution Greater Baltime	-		0 . *	4b. City, Town, o	or Location of De	eath		nty of Death :imore	
	waaval		. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 h	Hrs. 8. Date of B	idh		place (State or Foreign
	uneral irector		211-10-3221	1□M 2 ∏ F	87	Yrs.	Months Days	Hours N	Feb 2	l, 1917	Cou	ntry) nsylvania
pu		-	Jsual Residence of Decedent		10.0	ty, Town or Lo						10.1.1.1.0
aryla	shov	.	0a. State 10b. County			•						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the M	28a-1	ect	Iaryland Baltin	nore Coun	ty	<u>Parkvi</u>	10f. Zip Code			10g. Citizen	of What Cou	Λ
√ ∮	The C	2	64 Roger Val	lev Court				.234		Tog. Onzen	USA	intry :
- Hoath	ms 2:	era	1. Marital Status	12. Was Dec	edent Ever in U	I.S. 13.			(Specify Yes or Nuerto Rican, etc.)	lo- 14. F	ace - Amer	
after 6	or ite	by Funeral Director	1 Never Married 2 Marr	ied Armed F I ☐ Yes If Yes, G	2 ₩ No		r Yes, speciny Cub 1 ☐ Yes 2√2 No		Jeno Hican, etc.)	Spe	lack, White	
HWHA 0036 hours after death with the Maryland	LEXE	g p	3 Widowed 4 □ Divorced	Year or I	Dates:							nite ————————
15-0	"nat	Completed	15. Deceden (Specify only highes	t's Education st grade completed		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	oation during most of d)	working	16b. Kind of	Business/Ir	ndustry
21215- d within 72	than The M	E O	Elementary/Secondary (0-12)	College	1-4or 5+)		cretary	-/		Medic	al Re	cords
DG 25	otha vant.	Bec	7. Father's Name (First, Middle,	Last)				18. Mother's I	Name (First, Middl			
arylan sand Mental	arkad atic e	0	Jacob Okolo	ovitch				Mary		(Unkno	wn)
Man 2 sho	ls m		19a. Informant's Name/Relations	hip (Type, Print)		I som on			Rural Route Num.			
e, R	Important: If item 21 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Exercities intelliged at once.		Robert J. Gilbert J. G	ert (Son) 20h I	64 R	oger Vall	Ley Cour	rt, Parkv	ille, N		
- Time # 1	or o		1 ☐ Burial 2 X Cremation	3 Removal from	State	cemetery, crei	natory or other pla	1				
altimor mit. Pages	injury	ī	' 4 □ Donation 5 □ Other (S 21. Signal of Fundat Servize	4	Mo		Mem Pk Name and Addre		19/2005	Baltim	ore,	Maryland
Balti	Impo any ir once.		Martin D. I.	abean	m	M	itchell-V	Viedefel	ld Funera			
		1	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the deat	th. Do not ent	od Zork	Road car	altimore	Mary]	and 2	1212 Approximate Interval Between
PIIV	sician		Immediate Cause (Final disease or condition	only one cause on	v bale	1.00						Onsel and Death
/M	ledical		resulting in death)	a. Duen	(ras a consec	quence of):						10
Exa	iminer		Sequentially list conditions,	b/		min						day,
p	asit .	Examiner	Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dueto	(or as a consec	quence of):						
60, be executed	al-trar	xau	hat initiated events resulting in death) Last	c	(or as a consec	quence of):						
8760 , sate be e.		dical		d								_
	as th	ed -										· · · · · · · · · · · · · · · · · · ·
Box	tendir or use	an/N	F FEMALE: 23b. Was decedent pregnant in the past 12 pronths?	23c. If yes, ou 1 ☐ Live	itcome of pregnation		Ectopic pregnanc	y			Date of deliv	ery Day Year
O. Et	the at hed fo	Physician/Me	1 ☐ Yes 2 ☐ No. 9 ☐ Unknown	4□Preg 9□Unkr	nant at time of o	leath 5	Other (specify) _				AIGHUI	Day 1 ear
P.O. Box 6			Part II. Dther significant condition	ons contributing to	leath but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use co	ntribute to t	the cause of death?
	n sign	d by							1	Yes 2□No	3 🗌 Pro	bably 4 Unknown
Records, The law requires	shou	Completed							24a. Wa	s an 241	o. Were auto	opsy findings available
Be	certificate has t	E O								ormed? 2 XNo	prior to co death? 1 \sum Yes	mpletion of cause of
ig ig	rtifica xtor, p	-	25. Was case referred to medical examiner?					26. Place of I	Death (Check only		1 103	2010
of Vita Physician:	his ce I direc	0	1 Yes	Hospital:	Inpatient 2	ER/Outpatier	1 3 DOM		g Home 5 ☐ Res			fy)
n o d o d	After this funeral di	.: 0	27. Manner of Death 1 ☑Natural 5 ☐ Pendin	9	of Injury oth, Day Year)	28b. Time of Injury	Wo		28d. Describe	how injury occ	urred	
Division of Vital Records for Attending Physician: The law requires	tor: /	Certification:	2 Accident investig 3 Suicide 6 Could	not be	o of Injuny - At h	ome farm etr	M 1 ==	Yes 2 No	28f Location	(Street and Nu	nher or Pur	al Route Number,
Div Jor A	Dirac J in by	ertit	4 Homicide determ	ned build	ing, etc. (Speci	fy)	eet, lactory, office			wn, State)	11007 07 11071	arriosto variosi,
spita	y filled	<u>a</u>	29a. Certifier 12 Certifyin	g Physician: To th	e best of my kno	owledge, deatl	occurred at the ti	me, date and pl	ace, and due to the	cause(s) and	manner as s	stated.
Division To the Hospital or Attending	To the Funeral Director: After this certific completely filled in by the funeral director,	edical	(Check only 2 Medical one)	Examiner: On the land man	ner stated.	ation and/or in	vestigation, in my o	ppinion, death o	ccurred at the time	, date and plac	e, and due t	o the cause(s)
Tot	To Co	Σ	29b. Signature and title of certifie.				29c. Licens	Se number	()	29d. Date sign	ned (Month,	Day, Year)
	1		n	5 mm			V	- 1	0/	11	6/2	
	り		The sum of	who completed cau	se of death (Iter	п 23а/ (Туре,	le st. Be	House	mp 21	204		
	Stat	e	31. Date filed (Month, Day, Year)		Registrarit Signa		boarte	1				
X	Registra	6	JAI	4 1 9 2005	Julia de	Sales age to	2					

			For State Registrar		State	of Mar	yland	-	artment of I				Reg. No.		5	0103	5
	Dhuaiai		1. Decedent's Name	(First, Middle, L	ast)							2. Date of De	eath Day		Year	3. Time of Dea	
	Physicia /Medic		Annie			Mae				een		Janua		720	<i>b</i> S_	12:151	. M *
	Examin	er	4a. Facility Name (If						4b. City, Town, o					County		ا ماما	
	Franci		North A: 5. Social Security No.		Hospi Sex		'In yrs. I	ast birthday)	Glen Bi	If Under	24 Hrs.	8. Date of Bi		ne i			reign
	Funeral Director		246-14-	0226	1□M 2 X F		83	Yrs.	Months Days	Hours	Min.	8. Date of Bi (Month, Di 03 20	2 Year)	1	Cour	lace (State or Fo try) NC	
	and w		Usual Residence of 10a. State	10b. County		1	0c. City	, Town or Lo	cation						1	0d. Inside City Li	imits
	Mary -1 sho	tor	MD	Anne	Arund	el	G1	en Bu	rnie							1 □ Yes 2 X	ON
	h the	Director	10e. Street and Num	nber					10f. Zip Code				10g. Citi	zen of W	hat Cour	try?	
	23a (23a (23a (23a (23a (23a (23a (23a (aiD	7466 Ea	st Fur	ance B	ranc	h R	load		21061				.S.	A •		
	tams	nue	11. Marital Status		12. Was De	cedent Eve Forces?	er in U.	S. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Or an, Mexica	igin? (Sp n, Puerto	ecity Yes or No Rican, etc.)	0-		- Amend , White,	an Indian, etc.	
36	hours after death with the Maryland tural; or Itams 23a or 28a-f show al Examinar must be notified at	Completed by Funeral	1 Never Marrie		If Yes, (Year or	s XX No Give Dates:			I□Yes 2XNo	Specify.	:			Specify:	Bla	ck	
5-0036	72 hou	ted		15. Decedent's ify only highest of	Education	-()		16a. Dece	lent's Usual Occup kind of work done OO NOT use retire	pation	st of work	rina	1	nd of Bus	iness/in	dustry	
25	within 7 ene. than "r	nple	Elementary/Secon	ndary (0-12)		(1-4or 5+)									Bus	iness	
24	filed w Hygier thar tl		12th gra		na_			Info	rmatio			111ST e (First, Middle	Bur		.)		
and	aryland aryland aryland should be fill and Mental H Munatic even To Be 12.		· ·		·							largie			/		
a VI	Maryla d 2 should th and Men 7 Is marke traumatic		William 19a. Informant's Na					19b. Mailir	g Address (Street						tate, Zip	^{Code)} 210	61
Z	and 2 ealth a n 27 ls		Cecelia	McLeo	d-Daug	hter			Scotts 1	Mano	c Dr	ive,				Md Md	
ore	of He		20a. Method of Disp	osition Cremation 3	☐Removal from	m State	CE	emetery, crer	sition (Name of natory or other pla			Date			•	wn, State	
E	Limore, It. Pages 1 an riment of Heal riams. If item 2 njury or other		° 4 □ Donation	5 Other (Spec	cify)		Gar		r Fores			./25/0	5 Ow	ing	s Mi	.11, Md	
Ba	permit. F Departm Importar any injui		21. Signature of Fur	neral Service Lic	ensee	him	14	Ma	Name and Address	H Wes	st.	n=1+	4		4.47	21215	
			3a. Phrt1. Enter th	ne disease, or co	mplications ha	t caused th	e death		300 Wab					e, i	1G _	Approximate	
	Physician		I priediate Cause (t failure. List on Final	10	each line.	\ \	0	1 101						1	Onset and Deat	h h
	/Medical		disease or condition resulting in death)		a	o (or as a		ience of):	Com	in							
	Examiner		Sequentially list con	nditions.	b. C	MON	an	na	ten 1	dose	mile	<u>}_</u>					
	ed isit	ine	Sequentially list con it any, leading to lift cause. Enter Under Cause (Disease or i	riving	Dust	onoras a s	La	ence of):	0:41	4							
14	xecut and al-trar	Examiner	that initiated events resulting in death) L		c. Due t	o (or as a c	consequ	uence of):	3 necu	<u>mo</u>					-		
,760	ate be executed nysician and he burial-transit	cai			d											_	
.89	tificat ng phy as th							-					1				
Box 68	death certifical e attending phy of for use as th	an/N	23b. Was decedent in the past 12		23c. If yes, o	outcome of birth 2			Ectopic pregnanc	у			2	3d. Date		ry Day Year	
	0 0 0	Physician/Med	1 Yes 2 D		4 □ Pre 9 □ Unk	gnant at tin known	ne of de	eath 5	Other (specify) _					WOIT		Day Tour	
P.O.	Physician: The law requires that the de this certificate has been signed by the a ral director, page 2 should be detached f	/ Ph	Part II. Other signifi	icant conditions	contributing to	death but i	not resu	ilting in the u	nderlying cause gr	ven in Part	I.	23e. Did	tobacco u	se contril	oute to th	e cause of death	17
rds	quires n sign	ed by										1 🗆	Yes X	No :	B □ Prob	ably 4 Dunkn	iown
000	law require as been si 2 should b	Completed										24a. Was		24b. W	ere auto	osy findings avail	lable
Ä	The lav	Com										perfe	ormed? 2 No	de	ath?	2□ No	, 01
/ita	ician: Th certificate rector, pag	Be	25. Was case referr examiner?	red to medical	Manaitali *	,					e of Dea	h (Check only	one)				
of	Physi this c	<u>P</u>	1 Yes 2	No	Hospital: 1	Inpatient of Injury		ER/Outpatier 28b. Time of	1 3 DOW	10 a 100	ursing Ho	ome 5 Resi				')	_
on	Attending r death. actor: After	tion	1 Natural 2 Accident	5 Pending investigat	(Mc	onth, Day Y	(ear)	Injury	Wo	rk?]Yes 2 □	No			, , , , , , , , , , , , , , , , , , , ,	_		
Division of Vital Records,	Atter actor by the	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	200. Pia	ce of Injury Iding, etc. (- At ho	me, farm, str	eet, factory, office			28f. Location ((Street and wn, State)	d Numbe	or Rura	l Route Number,	
ā	ital or irs afte ral Dira led in t		- Commondo	. /	00,	iding, oto. (Opcony	/									
	To the Hospital or Attending Physician: within 24 hours after death. To the Furaral Director: After this certific completely illed in by the funeral director,	edical	29a. Certifier (Check only one)	1 Certifying 2 Medical Ex	aminer: On the	he best of a basis of ex anner state	xaminat	wledge, deatl ion and/or in	occurred at the ti vestigation, in my	me, date ar opinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) date and	and man place, ar	ner as st id due to	ated. the cause(s)	
	To the within 2 To the comple	Mec	29b. Signature and	title of certifier	and me		·		29c. Licens	se number			29d. Date	e signed	(Month,	Day, Year)	
	- s = ō		1 Acm	Va)			MA	1	DA	397	7		Jan.	16 a De		7 200	5
	1		30-Name and add	ess of person wh	o completed ca	use of dea	th (Item	23а) (Туре.	Print).	Δ	(\	-000	VVVV	7	7 01000	
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	Sta Registra		31. Date filed (Mont	th Day, Year)	2005 32.	Begistrar	s signat		BALL!						,		
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		State of Maryland / Department of Health and Me	-	_	
		1- For State Registrar Certificate of Death		No 2005	01036
Physic	ian		Date of Death Month	Day Year	3. Time of Death
/Med Exam	ical	Anthony F. Genovese Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	January	4c. County of Death	1 co print
Zxaiij	inei	Harford Memorial Hospital Bel Air		Harford	
Funera Directo	_	5. Social Security Number 6. Sex 212-20-2334 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthpla Counti	ice (State or Foreign y)
ъ		Usual Residence of Decedent	Jul 01,	1924 Mary	land
15-0036 72 hours after death with the Maryland "natural", or Items 23a or 28a-f ahow dical Exama an imast be incliffed at	20	MD Harford 10c. City, Town or Location Bel Air		10	d. Inside City Limits 1 ☐ Yes 2 No
036 ours after death with the Maryla rel; or ferms 23a or 28a-1 ahov Exural me mush be, rediffed al	Director	10e. Street and Number 10f. Zip Code	10g.	Citizen of What Country	
ith with 23s o		404 Aggies Circle- Unit A 21014	Un	ited Stat	es
	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri	effy Yes or No- lican, etc.)	14. Race - America Black, White, et	n Indian,
O36	þ	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No 44 - 45 If Yes, Give 1 □ Yes 2 ☑ No Specify:		Specify: Whit	e
1215-0036 within 72 hours after ane. than "naturel; or lite is Medical Everta	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) 10 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Unknown				istry
	dmo	Elementary/Secondary (0-12) College (1-4or 5+) 1 (College (1-4or 5+) Unknown			
laryland 21215 2 should be filed within 7. and Mental Hygiene. is marked other than "n aumatic event, the Med	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name ((First, Middle, Maid	den Sumame)	
aryland S should be fill and Mental H is marked out	P Anthony Genovese Dorothy Hurley				
Maryla to 2 should lith and Mer 27 is market traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 Aggies Circle-Unit A, Bel Air, MD.21014			
ore, M		20a. Method of Disposition 20b. Place of Disposition (Name of Date of Disposition (Name of Date of Date of Date of Disposition Date of	10 200	Location - City or Tow	n, State
Baltimore Bartimore Bearing Pages 1.4 Bearing Pa		1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 2005	Be	ltsville,	MD.
Baltimore, permit. Pages 1 a Department of Her Important: if them sonce.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives			
7		22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Dr. Baltimore MD. Approximate Interval Between Interva			
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/Medical		resulting in death) Due to (or as a consequence of):			T Cago
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Box 68 Box 68 leath certificat	an/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery	
O. B le deat the att	sicia	in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown		Month D	ay Year
P.O.	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d				cause of death?
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al R in The in T	25. Was case referred to medical examiner? 10. State of Death (Check only one) 10. Other: The control of Death (Check only one)				
Vita Vita rsician					
n of ng Physical control in the residue of the resi	Hospital: 1 mpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
Sion Sion Sion Sion Sion Sion Sion Sion	Accident 3 Suicide 4 Homicide 4 Homicide 4 Homicide 5 See Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 286. Place of Injury - At home, farm, street, factory, office City or Town, State)				
Divi					Route Number,
Ospita hours uneral ly filled					
the H hin 24 the Fi	Medicai	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
To with	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day) 29c. License number 29d. Date signed (Month, Day)				
1					
101	VINCENTA, Giminuro Do 602 South Atwood Kee & Suite 205 Kee Air, MD 21014				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vincent A. Giminaro Do 602 Sowth Atwrov Rev. Swite 208 Psel Air, MD 21014 State Registrar JAN 1 9 2005 JAN 1 9 2005					

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			1 _ State		artment of Health and I <i>rtificate of Death</i>		711115	01037
	_	-0	Registrar 1. Decedent's Name (First, Middle, Last)		Timodio or Bodin	2. Date of Death	i. Nd;- 0 0 0	3. Time of Death
Н	Physici		Franklin W. Gill			January	Day Year 12 2005	5:40 a м
je.	/Medic Examir		4a. Facility Name (If not institution, give street and n	umber)	4b. City, Town, or Location of Deatl	-	4c. County of Death	
			1265 Poplar Avenue		Baltimore		Baltimore	
	Funeral		5. Social Security Number 6. Sex 12 M 2 □ F	7. Age (In yrs. last birthday) 70 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	(Month Day)	(ear) 9. Birth	nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	70 113.		Jan 15,	1934 Mar	ryland
	yland Now		10a. State 10b. County	10c. City, Town or Lo				10d. Inside City Limits
	a-f et	ctor	Maryland Baltimore	Balti	more			1 ☐ Yes 2 No
	or 28	Jire	10e. Street and Number		10f. Zip Code 21227		citizen of What Col	
	filed within 72 hours after death with the Maryland Hygiene. other then "natural", or tems 23s or 28s-1 show ont, it a Medical Exacitive mark he notified at	Funeral Director	1265 Poplar Avenue				14. Race - Amer	
	Item Item	une	Amed 6	rcedent Ever in U.S. 13. Forces? 5 2 □ No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White	e, etc.
99	urs af	þ	3 ☐ Widowed 4 ☐ Divorced Year or	Give Dates:	1 ☐ Yes 2 A No Specify:		Specify: WI	ite
Q 2	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade completed	d) (Give	dent's Usual Occupation kind of work done during most of wor	kina 16	b. Kind of Business/l	ndustry
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2	Hygie ther t	Co	17. Father's Name (First, Middle, Last)	- Ula		ne (First, Middle, Ma		s CICY
au	m - 0 5	To Be	Stanley Gill		Ruth	Sugars		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Manylan and Mental Hygiene. Is marked other than "natural", or Items 23e or 28e-f ehow aumstic event, the Medical Examinating the notified at	-	19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Ru			
Σ,	and 2 ealth in 27 I		Mary Lee Gill / Wife		Poplar Avenue, Ba	242 E		
Baltimore,	or of		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from	n State 20b. Place of Dispo	osition (Name of matory or other place)		c. Location - City or 1	
ΙξίΤ	it. Pa intmen intent injury		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service/Licepsee,		Ige Mem. Park 1/15 2. Name and Address of Facility Hu			
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev ance.		Inn U Sank		1107 Wilkens Avenu			
	1 5 1		23a. Part1. Enter the disease of complications that shock, or heart failure. List only one cause on					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Lindle stone	a multifor			Onset and Death
	/Medical Examiner		resulting in death)	o (or as a consequence of):				
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ν, L	w requires that the de been signed by the should be detached	by PI	Part II. Other significant conditions contributing to	death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	oco use contribute to	the cause of death?
ecords	requires een sign hould be					1 ☐ Yes	2⊠No 3□Pro	bably 4 Unknown
ပ္တ	60 S CA	ompieted				24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
Vital H	Th ate	O					d? death? No 1□Yes	2 No
2	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	31	Othon	th (Check only one)	e 6 □Other (Speci	*
0	y Phys ar this eral di	\succ .	27. Manner of Death 28a. Date	Inpatient 2 ER/Outpatien e of Injury 28b. Time of		28d. Describe how		ny)
0	ath. r: Afte	atio	1 ANatural 5 ☐ Pending (Mo 2 ☐ Accident investigation	nth, Day Year) Injury	M 1 Yes 2 No			
Uivision	or Atta	Certification:		ce of Injury - At home, farm, str ding, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,
ב	pital o	Ce	20 Carifornia 157 Carifornia Physician 7 and					
	a Hos 24 ho a Fun etely f	edicai	(Check only 2 Medical Examiner: On the		h occurred at the time, date and place vestigation, in my opinion, death occu			
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Me	29b. Signature and title of certifier		29c. License number	29d	Date signed (Month,	, Day, Year)
	11	1	1 alun	>	035254	\	19 05	
i	OY		30. Name and address of person who completed car	- 0 1	0 0 -	N A	0 2	O
_\	- / (31. Date filed (Month, Day, Year) 32.	Registrar's Signature	nave DALTIM	0156 100	カイバス	• 1
	Sta Registr		JAN 1 9 2005	Medure St.	bootes			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				olato ol marytan	Cer	tificate of	Death		Reg. No.	5 01038
			1. Decedent's Name (First, Middle, Las	()				2. Date of De Month	ath Dey Yea	3. Time of Death
1	Physicia /Medic	al	Dolores Grube					Jan.	12, 2005	2:00 PM
	Examin		4a Facility Name (If not institution, give				4b. City, Town, or L			1
(3)	9 '40		1224 North Rolling				Catonsvi		Balti	
	Funeral Director		212-20-4309	7. Age (In yrs. 79	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Apr 25	th ry, <i>Year</i>) , 1925 M	Birthplace (State or Foreign Country) aryland
	D .		Usual Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Loc	cation				10d. Inside City Limits
	ehone ehone	2	Maryland Baltimor		Catons					1 ☐ Yes 2 No
	the N	\$ E	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	23a or	Funeral Director	1224 North Rolli			21228			United St	ates
21215-0020	permit. Pagas 1 and 2 should be filed within 72 hours eftar daeth with the Menyland Department of Haalih and Mantial Hygiana. Important: if them 27 is marked other than "naturel", or items 23a or 28a-f show important: if them 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Examinar must be notified at once.	Ď	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates:	1	Vas Decedent of F Yes, specify Cub ☐ Yes 2 1 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes of No Rican, etc.)	Black, W	merican Indian, Thite, etc. White
5-0	72 hc	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Deced (Give)	ent's Usual Occup kind of work done	pation during most of work d)	ring	16b. Kind of Busine	ss/Industry
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2	ygiar yer th	ပ္ပ	10		Mana	ager	19 Methor's Nam	o /Firet Middle	Maiden Sumame)	Shecre bares
yland	ouid be fi Mantai H Irked ott	To Be	17. Father's Name (First, Middle, Last) Joseph F. Langley	7			Violet	Brewer		
, Mar	and 2 sho aith and 127 ie me er traum		19a Informant's Name/Relationship (7 Calvin C. Grube /		19b. Mailin	g Address (Street North Ro	and Number or Rui	d, Cato		aryland 21228
Baltimore, Maryland	Pagas 1 and of Hanners of the If Item		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	emetery, crem v Cathe	sition (Name of natory or other pla edral Cem	etery 1			, Maryland
Balti	permit. Dapartri Importa any Inju		21. Signature of Funeral Service Licens	Sink	22.	Name and Addre	ess of Facility Hu kens Aven	bbard F ue, Bal	uneral Hom timore, Ma	ne, Inc. aryland 21229
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	lications that caused the death	n. Do not ente	or the mode of dyin	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
1	Physician		Shoot, or hour failure. Elect 4.19	_	,					Onset and Death
	/Medical		Immediate Cause (Final disease or condition		onne	1980	1 Car	CIKOY	$n\alpha$	IVEAR
	Examiner		resulting in death)		r as a conseq					1
	pe tis	ie		b						1
	sacut e end el-trer	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consequ	uence of):				i
68760,	sicien t burie	al	cause. Enter Underlying Cause (Disease or injury that initiated events	C	r as a consequ	topico of):				1
× 68	entificate be executed ding physicien end se es the buriel-trensit	5 i	resulting in death) Last	d	1 as a consequ	Jenoe 01/.				
Box	ettane for us	Physician/						ant Did		and the description of description
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σ.	thet led by dete							10	768 21110 31	7 TODALLY 4 DOMINION
Records,	lew requires that the death certificate be executed as bean signed by the ettending physicien end a 2 should be deteched for use as the bunel-trensit	Completed by						24a. Was	en autopsy 24 ormed?	b. Were autopsy findings available prior to completion of cause of death?
ě	The lew eta has paga 2	Ĕ						10	Yes grand	1 ☐ Yes 2 ☐
	fficeta or, pe		25. Was case referred to medical				26. Place of Dea			
>	s cert direct	To Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient	t 3 DOA Oth	her.		dence 6 □Other (S	Specify)
on of	Attending Physician: If death. ector: After this certific by the funeral director,	lon: T	27. Manne Peeth 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo			how injury occurred	
Division of Vital	To the Hospital or Attending Physician: The is within 24 hours after dash. To the Funeral Director: After this certificate ha complataly filled in by the funeral director, page	Certification:	2 Accident 3 Suicide 6 Could not be 4 Homicide		ome, farm, stre	eet, factory, office			Street and Number of wn, State)	r Rural Route Number,
	To the Hospital within 24 hours a To the Funeral C complataly filled	edicai Ce	(Check only 2 Medical Exam	sician: To the best of my kno Iner: On the basis of exemina	wledge, death tion end/or inv	occurred at the tilestigation, in my o	me, date end place, opinion, death occur	end due to the red at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	the the f	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date signed (M	onth, Day, Year)
	F 1 5 0		200. Signature and title of certifier		mI	2	1617	70	lanin	11/12 m
	11/1	1	11/6	1	1111/	priha)	1101	10	Julua	11/10,000
	141.1		30. Negree and address of person where	completed cause of death (Item 2/055	Litte	2 Pa	tuxina	- Kal	KWay Ca	KMDIA, MD
*	Sta Registr	_	31. Date filed (Month, Day Year) 9	32. Registrar's Signa	ture				V	

			1 For State Registrar	State of Marylan	-	artment of H		nd Mental H	ygiene Reg. No. 005	01039
	Physici	an	Decedent's Name (First, Middle, Last) BARBARA MARGA	PET HARE				2. Date of D Month Jan.	Peath Day Yea 15 200	3. Time of Death 11:00 p M
	/Medic Examin		4a. Fecility Name (If not institution, give str			4b. Cily, Town, or	r Location of		4c. County of De	
			Wesley Home			Balti		id Hro To D	n/a	
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. 81	last birthday) Yrs.	Months Days	If Under 2 Hours	Min (Month I	Day, Year)	firthplace (State or Foreign Country) Cyland
	ס		Usuel Residence of Decedent		y, Town or Lo	oation		1001)		10d. Inside City Limits
	Manyla f ehov	ŏ	10a. State 10b. County Maryland Baltimore		timore					1 ☐ Yes 21 No
	r 28a-	Irect	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	ath wit	raiD	1710 Kennoway Road			2123			U.S.A.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "naturel", or Items 23e or 28a-f ehow important: if Item 27 ie marked other than "naturel", or Items 23e or 28a-f ehow important in the Traumatic event. The Modical Examinational Le modified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Orig an, Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)	Black, W	nerican Indian, nite, etc. hite
21215-0036	vithin 72 hound.	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most	of working	16b. Kind of Busines	
d 2	filed withi Hygiene. other than		12 17. Father's Name (First, Middle, Last)		Secr	etary	18. Mother	r's Name (First, Midde	Mortgage le, Maiden Sumame)	Danking
lan	Mental Mental Brked o	To Be	John Remson Onder	donk			Alex	andrina S	usanna Bort	on
Maryland	2 should n and Men ie marke		19a. Informant's Name/Relationship (Type			_			ber, City or Town, State , Maryland 2	
	s 1 and 2 of Health Item 27 i		Mr. James W. Hare (20a. Mathod of Disposition			osition (Name of matory or other place		Date	20c. Location - City	
SE SE	Pages nent of int: If I		1 Burial 2 □ Cremation 3 □ Rer 4 □ Donation 5 □ Other (Specify)	noval from State Dri	uid Ri	dge Cemet	ery 1	/19/05	Pikesvi	lle,Maryland
Baltimore,	permit. Pages Department of Introduced Introduced Introduced International Internation		21. Signature of Funeral Service Licensee	Krati		6500 Yor	ck Rd.	feld F.H. Baltimore	e,Maryland	21212
5.2			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	ations that caused the deat cause on each line.	h. Do not en	ter the mode of dyin	ig, such as o	cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	End 9 to Due to (or as a consec at her so	uence of):	emedia.		\		
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68760,	cate be	dicai	d.							
.O. Box 6	lhat the death certifical ed by the attending phy detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	it death 3[□Ectopic pregnancy □ Other (specify) _	′		23d. Date of o Month	delivery Day Year
<u>α</u>	es De pe	d by Ph	Part II. Other significant conditions controls 0.0 Stroke, N.	-	-		en in Part I.		I tobacco use contribute	to the cause of death? Probably 4 Dunknown
of Vital Records,	ne law requir has been s ge 2 should	mplete						per	opsy prior t formed? death	
ta		0	25. Was case referred to medical				26. Place	of Death (Check only	2 No 1 Y	es 2 KZ No
Ž	S S	To B	TE TOS ZINO		ER/Outpatie		4 [3 140]	rsing Home 5 ☐ Re	sidence 6 □Other (S	pecify)
ouc	fter ine	:lon:	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2∐1		how injury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st			28f. Location	(Street and Number or own, State)	Rural Route Number,
	ne Hospit n 24 hours ne Funera	edical (29a. Certifier 12 Certifying Physic (Check only one)	cian: To the best of my kno er: On the basis of examina and manner stated.	owledge, deat ation and/or in	th occurred at the time execution, in my o	ne, date and pinion, deat	d place, and due to the h occurred at the time	e cause(s) and manner e, date and place, and d	as stated. ue to the cause(s)
.	To the virthin To the comp	W	29b. Signature and title of certific	Ti.		29c. Licens			29d. Date signed (Mo	nth, Day, Year)
,	\sim		K.T. Filsey	s,ms.	- 00:1	Par			1-17-05	
	10		30. Name and address of person who com PORETT LIBOUTO, MO	. 3708 Bau	11 23a) (Type,	Bulto	2122	4		
	Sta		31. Date filed (Month, Day, Year) JAN 1 9 200	ipleted cause of death (Iter . 3 TO 8 Box 32. egistrar's Signa	ature.	bach		•		
	Regist	eli.	DAIN T 3 ZOO	O DESCRIPTION OF	0 3					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 3:45 January 15, 2005 EVELYN GARNETTA DISNEY HARPER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore City Alice Manor Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec 2, 1904 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1□M 2₩F Maryland 100 216-03-7255 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or than "natural", or items 23a or 28a-f show the Medical Exercises must be notified at 1 1 Yes 2 □ No Baltimore City Director Maryland N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21211 2095 Rockrose Avenue Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: Saltimore, Maryland 21215-0036 þ 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Residence Homemaker is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be for and Mental F Mary Snoops ဥ Oliver Disney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum 90029. Bonnie L. Rosenthal (Pers. Rep.) 7313 Knollwood Road, Towson, Maryland 21286.

20a. Method of Disposition

| N Burial 2 | Cremation | 3 | Removal from State | 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City or Town, State | 20c. Location - City 1 N Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 1/21/2005 Woodlawn, Maryland Woodlawn Cemetery 21. Signate to of First Serve Serve away

Martin D. Lawson 22. Name and Address of Facility PIALLIN D. Lawson

23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximately a such as cardiac or respiratory arrest. Mitchell-Wiedefeld Funeral Home, Inc. tmmediate Cause (Final disease or condition resulting in death) Senile Dementio **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, na Stage Condition Physician/Medical IE EEMALE 23d. Date of delivery 23c. if yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Nnknown & raio= pulmongi Be Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1□Yes 2⊠No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident 5 Pending investigation To the Hospitel or Attendil within 24 hours after death. To the Funeral Director: At death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5311 old Hed Randollstown M.D., Tajudeen Ohiopehai, 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

			1 - For State of Maryland / Depar	tment of Health and Mificate of Death	ental Hygien	4005	01041
	0		Decedent's Name (First, Middle, Last)		2. Date of Death Month	ay Year	3. Time of Death
	Physicia /Medic		WILLIAM BOURDON HOLDEN			6, 2005	8:00 A. M
	Examin			4b. City, Town, or Location of Death	4	ic. County of Death	
			920 Tyson Street 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore If Under 1 Year If Under 24 Hrs.	P. Dato of Birth	N/A	alana (State or Familia)
	Funeral Director			Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Sept. 2,	1927 Ohj	olace (State or Foreign
		-	Usual Residence of Decedent		БСРС. 2,	1/2/ 011	.0
	how		10a. State 10b. County 10c. City, Town or Local	ition			10d. Inside City Limits
	Ba-fs	cto	Maryland N/A Baltimo	re	· · · · · · · · · · · · · · · · · · ·		1∭Yes 2☐No
1	or 28	Dire	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Cou	ntry?
	a 23e	rai	920 Tyson Street 11 Marital Status 12. Was Decedent Ever in U.S. 13. W.	21201	cifu Voc or No	U.S.A.	can Indian
_ 1	Item Item	Funeral Directo	Armed Forces?	as Decedent of Hispanic Origin? (Spe fes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, White,	
20	urs at	Ď	1 □ Never Married 2 □ Married 1 1 X Yes 2 □ No If Yes, Give 12 □ No If Yes, Give Year or Dates: 1955–57	☐Yes 2xxNo <i>Specify:</i>		Specify: Whi	te
213-0030	be lied within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene. Ad other than "natural", or Itema 23a or 28a-f show event, the Modical Evaminer must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) (Give ki	nt's Usual Occupation nd of work done during most of workir	16b.	Kind of Business/Ir	dustry
V	nithin Den.	nple	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired)		D 1.	
ν.	fygier tygier her tt		5+ years Psyc	chiatrist	(First, Middle, Maid	Psychia	try
yland	ntal Hed of	Be	John Adrian Holden	Fleuran		ntegut	
	2 should be and Mental Is marked (၉		Address (Street and Number or Rura			o Code)
	od 2 :			7 Roxbury Ave. St	ringfield	1. Vircin	ia 22152
e,	of Hear		20a. Method of Disposition 20b. Place of Disposition			Location - City or T	
Ē	Page		1 □ Burial 2 □ Cremation 3 □ Removal from State `4 □ Donation 5 □ Other (Specify) Entombment St. Peter		-05 Res	serve, Lo	uisiana
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evone.	4	21. Signature of Funeral Service Licensee 22.	Name and Address of Facility	Funoral E		
_	20129		Skore/ferrom 65	Name and Address of Facility tchell-Wiedefeld 00 York Road Bal	timore, N	lary land	1212
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	the mode of dying, such as cardiac or	r respiratory arrest.		Approximate Interval Between Onset and Death
F	nysician	9 5	Immediate Cause (Final disease or condition resulting in death)	t			
ı	/Medical Examiner		Due to (or as a consequence of):	th			year
	H88 4	er	Sequentially list conditions, If any leading to immediate Due to (or as a consequence of):				,
1	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				·
Ş	ate be executed hysician and he burial-transit		resulting in death) Last Due to (or as a consequence of):				
9/90	death certificate be executed e attending physician and id for use as the burial-transit	licai	d				
× ex	ertific ding p	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			201 0-1-11	
X O D	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	in the past 12 months?	ctopic pregnancy Other (specify)		23d. Date of deliv Month	Day Year
o	the d ry the ached	ysi	1 Yes 2 No 9 Unknown	,,			
J.	requires that the neen signed by th hould be detache	by PI	Part II. Other significant conditions contributing to death but not resulting in the unc	lerlying cause given in Part I.	23e. Did tobacc	o use contribute to	he cause of death?
ra	w require been sig should b				1 Tes	2□No 3□Pro	bably 4 Minknown
ecords,	> 40	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
r ,	The law cate has b page 2 s	Con			performed?		2 🗆 No
Vital	i lcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:		(Check only one)		
0	Phys rthis ral di	. To	1 Inpatient 2 EH/Outpatient	3 DOA Other: 4 Nursing Hon	ne 5. Wesidence 28d. Describe how in		fy)
o	iding Phy th. : After thi funeral	tion	27. Manner Death 1 \text{ tural } 5 \text{ Pending investigation} 2 \text{ Accident } 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)	28c. Injury at Work? M 1 Tyes 2 No		,	
Division	Attendi ar death. ector: A by the fu	ifica	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determed 28e. Place of Injury · At home, farm, street building, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, Sta		al Route Number,
5	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Alte completely filled in by the fune	Certification:	Outliding, etc. (Specify)		o., c. 10m, ote		
	Hospi 4 hou Funer ely fill	edicai	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or inve				
	thin 2 the mplet	Med	and manner stated. 29b. Si parture and title of certifier	29c. License number	29d [Date signed (Month,	Day, Year)
	F N F S		290. Si Natura di dyna of cannai	057119		T. 10	
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, P	rint),			5002
	V		Daniel Levy, m 6701 N. Cha-les	St. #STOS T	duson, Mo	51507	
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature	. K. P			
	Registi	ar	JAN 1 9 2005 Januar Jo. Agr				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month **Physician** House 19:14 PM Januar 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore University of Maryland HOSPIta 1 Baltimore. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 254F 63 217-38-8562 Director 1an Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits orient: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event. Its Medical Examinar milet be restilled at Baltimore 1 XYes 2 □ No Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21215 2805 400 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after and Mental Hygiene. 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use rejired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1edica 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: if Item 27 is marked other any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Ethel terbert Touse Hant 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Date 20a. Method of Disposition ■ Burial 2 □ Cremation 3 □ Removal from State A ☐ Donation 5 ☐ Other (Specify) Jan 21 2005 21. Signature of Funeral Service Licensee ulloh 23a. Part 1. Enter the disease, or complications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Malignant /Medical **Examiner** Sequentially list conditions, if any leader to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 □Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform rmed2 2 V No 1 Yes 1 ☐ Yes 2 ☐ No Hospitei or Attending Physician: 4 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑Natural Date of Injury (Month, Day Year) Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerei D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) David Ghadisha M.D AU4176435G15183 January 13 2005 address of person who completed cause of death (Item 23a) (Type, Print) Ghadisha M.O 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY **Physician** Ĩ3, 2005 10:20 P M Holloman Morton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**XX**M 2□ F Months Days Hours Min. 63 Director 21, 1941 North Carolina 241-60-5409 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28e-f show other traumatic event, the Medical Examinar must be undiffied at 1 ☐ Yes 2 🕅 No Silver Spring Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20903 10120 New Hampshire Ave. #102 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status tyTyYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√√No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry f Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Electrician Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Holloman Lucille F1vn Willard Luby 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2090319a. Informant's Name/Relationship (Type, Print) 10120 New Hampshire Ave. #102, Silver Spring, MD Elizabeth A. Holloman / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 Burial 2XXCremation 3 Removal from State
4 Donation 5 Other (Specify) Beltsville, MD Chesapeake Crematory 1/18/05 21. Signature of Funeral Service Lizensee 22. Name and Address of Facility
Rapp Funeral and Cremation Services Rapp Funeral and Cremation Space Rapp Funeral Rapp Funera 933 Gist Ave., Silver Spring, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ENGRENION (0) /Medical Due to (or as a sequence of): Examiner 0513 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (as a consequence of): Examiner the death certificate be executed FAILUNG 545 PIRATORY burial-tran Due to (of as a consequence of): Physician/Medical \$µe as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached the 9 Unknown þ signed b Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has CV. autopsy performed page certificate 2 No 1 TYes 2 □ No Physicien: director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

Inerel Director: After this y filled in by the funeral d this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitel within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AHMEX DR. TAHMINA CARROIL 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 9 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Mark

			For State Registrar			yland / [Оера		t of H	ealth a		lental Hy	giene	2001	; 01	01.1.
			Registrar 1. Decedent's Name (First, Middle,	Last)			Cel	uncau	OIL	Jeaui		2. Date of De	Reg. No.	-00,	3. Time o	of Death
	Physicia		Edith Ethel Hend									Month Januar		, 2005		
	/Medic Examin		4a. Facility Name (If not institution, 300 Ivy Church F		mber)			4b. City,		Location o			4c.	County of De	ath	
			-	S. Sex	7 Ann //	n yrs. last bii	thday)	If Under		If Under		8. Date of Bir			irthplace (State	or Foreign
ı	Funeral Director		165-24-9576	1 M 2 StF	r. Ago (r	7.4	Yrs.	Months	Days	Hours	Min.	Jun 15,	193	0 PA	Country)	or roragir
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10	Oc. City, Tow	n or Lo	cation							10d. Inside (City Limits
	d sho	ō	MD Baltime	ore	1	Luther	vil	le Ti	moni	um					1 □ Yes	2 2 No
	1 the	rec	10e. Street and Number					10f. Zip	Code				10g. Citi	zen of What	Country?	
	h with	Funeral Director	523 Morris Avenu	e				2109	3			1	USA			
	deat	ner	11. Marital Status	12. Was Dec	edent Eve	er in U.S.	13.	Was Deced	ent of His	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)	0-	14. Race - Ar Black, Wi	merican Indian,	
9	or It		1 Never Married 2 Marrie	d 1 ⊟Yes If Yes, Gi	2 E∜No ve			1 □ Yes		Specify:			1	Specify: Whi		
ğ	hours tural	q pe	3. 3. 3. 4. □ Divorced 15. Decedent's	Year or D	ates:	162	Deco	dent's Usua	Cocupa	tion				WN1		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show ha Madical Examinar must be maillised at	Completed by	(Specify only highest	grade completed)	4.45-)		(Give	kind of wor DO NOT us	k done d e retired)	uring mos	t of work	ing	Own		sariidusiiy	
212	d with giene ir tha	mo:	Elementary/Secondary (0-12) 12	College (1-40r 5+)	Ног	nema	aker								
9	be filed within 72 hours after death with the Marylan nta! Hygiene. I do thar than "natural", or Items 23a or 28a-1 show evant, the Medical Examinating must be multipled at	Bec	17. Father's Name (First, Middle, L	ast)								(First, Middle		Surname)		
<u>X</u>	2 should be and Mental is marked raumatic ev	5	Aaron Ling							Nelli		auerbr				
Maryland	nd 2 shallth and 27 is m		19a. Informant's Name/Relationsh David Hendricks/					•				a <i>l Route Numb</i> ettysbu:				
ē,	S 1 al	9	20a. Method of Disposition			20b. Place o	f Dispo	sition (Nan	ne of ther place	9)	J T.	Date an 18	20c. Lo	cation - City	or Town, State	
Ē	Page nent c ant: If		1 ☐ Burial 2 ☑ Cremation · 4 ☐ Donation 5 ☐ Other (Sp			Chesar						005	Belt:	sville	, MD	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 is marked any injury or other traumatic an once.		21. Signature of Funeral Service L	censee	HOOR	86	C	Name an remat 717 G	ion	and I	une	cal Alt B Drive	erna Ba	tives ltimor	e. MD	
			23a. Fartt: Enter the disease, or of shock, or heart failure. List of	omplications that	caused the	e death. Do									Approxima Interval Be	tween
	Physician	2	Immediate Cause (Final disease or condition	. 54	TU A	mou	25	cell	2 (Mac	:cn	oma of	Vu	LUA	Onset and	Death
	/Medical Examiner		resulting in death)	Due to	or as a c	onsequence	of):			State of State of		0				
	Lxammer	_	Sequentially list conditions,	b. Due to	luras a c	unsequence	offi-									
	ted nsit	nlne	Sequentially list conditions, if any, leading to initially cause. Enter Underlying Cause (Disease or injury	Cucit	(0.000.00	or no quoi ne	Cey.								1	Į.
Ć,	te be executed ysician and te burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a c	onsequence	of):									
760,	w = 0	cal	1	d										_		
89	tifica 19 pt as th	Med	IF FEMALE:													
Box	death certifica e attending ph ed for use as th	lan/l	23b. Was decedent pregnant in the past 12 months?		birth 2 [☐ Fetal déath		Ectopic pr					4	23d. Date of o	lelivery Dav	Year
0	0 0 0	yslc	1 □ Yes 2 No 9 □ Unknown	4□Pregi 9□Unkr		ne of death	5	Other (sp	өспу)						•	
۵.	es that the death cer igned by the attendin be detached for use	by Physician/Med	Part II. Other significant condition	s contributing to d	eath but r	not resulting i	n the u	nderlying c	ause give	n in Part I		23e. Did	tobacco u	se contribute	to the cause of	death?
rds,	The law requires that the tee has been signed by th bage 2 should be detache											1 🗆	Yes 2	ZK0 3□	Probably 4	Unknown
Record	aw re	Completed										24a. Was		24b. Were	autopsy findings o completion of	available
		Com											ormed? 2 No	death	?	54455
Vita	Physician: The ribis certificate har al director, page	Be	25. Was case referred to medical examiner?									(Check only		***	Dough	tens
0	£ 5 =	J.	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 🗆	Inpatient	2 EPVO	utpatier Time of		A Othe	^{17:} 4 □ Nu		me 5 Res		Other (S)	pecity) (2 5	Idena
Division of	ding h. After funer	tlon	1 Natural 5 ☐ Pending	(Mor	ith, Day Y		Injury	M	8c. Injury Work	:?`` ∕es 2 🔲	- 8	200. 00001100	now injur	Cocumba		
/ISI	l or Attending P after death. Diractor: After t I in by the funera	ifica	3 Suicide 6 Could no	ot be 28e, Place	of Injury	- At home, fa	arm, str	reet, factory	, office		8				Rural Route Nui	nber,
ā	s afte	Certification:	4 Homicide	build	ing, etc. (Sреспу)						City or To	wn, State	,		
	tospit thour uner	edical (29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the xeminer: On the b	a best of n	ny knowledg	e, death	h occurred vestigation.	at the tim	e, date an	d place, th occur	and due to the	cause(s)	and manner	as stated. ue to the cause(s)
	To the Hospital or A within 24 hours after To tha Funeral Dirac completely filled in by	Med	one) 29b. Signature and title of certifier	and mar	ner stated	d. In		290	License	number			29d Dat	a signed (Mo	nth Day Year)	
•	⊢ 3 ⊢ ŏ		10/1/	1hins	11	l_	u	n	02	450	05	-	JA	IVAY	114,2	005
	6		30. Name and address of person v	no completed cau	se of deat	th (Item 3a)	Туре,	Print)		11	r. 0	0		1	414,2 Sto. N	2/2
	*		W.A.R.	ley	69	Mc		670)/	14- (-le	ules	11	. 50	lto, N	15'40
	Sta Registr		31. Date filod (Month, Day, Year)	3201	Registrar's	Signature	ha	rele?								
	Registr	वा	JAN 1 9 2	11115 100	32181	No.	AFER	The state of the s								

			Please	Type or Prin								_	e.	. 9 1079
			For State Registrar	State of Ma	-	Certificat			tria ivi		4	UUJ	0 1	045
			Registrar 1. Decedent's Name (First, Middle, Las	st)		Ochinoai	011	Cair		2. Date of De			3. Ti	me of Death
	Physici		Ricky La	ne Hine	5					Month Tanker	Da:	7 2	OCS &	2 5 PM
	/Medic Examin		4a. Facility Name (If not institution, give			4b. City	Town, o	Location o	of Death		•	County of I	Death	
			BALT: MORE VA	MediCAL	Cente	R BA	Ut.	MORE				YA		
	Funeral Director		218-58-5484	ex 7. Age KOKM 2□ F	(In yrs. last birt	Yrs. If Unde Months	Days	If Under 2 Hours	Min.	8. Date of Bir (Month, Da 2 12	th y, Year) 19	53	Birthplace (S Country) MD	tate or Foreign
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location							10d. Ins	ide City Limits
	Mary f sho	ţ	MD	N/A	Ba.	ltimore							1 🛭	Yes 2 □ No
	r 28a	Funeral Director	10e. Street and Number	_		10f. Zi	p Code				10g. Cit	izen of Wha	at Country?	
	th with	ai D	2601 Madison Av	enue ^{Api}	t. 604		212	217				USA		
	r dea	iner	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Was Dece If Yes, spe	dent of H	lispanic Orig an, Mexican	gin? (Spe i, Puerto l	city Yes or No Rican, etc.)	-		American Indi White, etc.	an,
36	ours after death with the Marylan rel', or Items 23e or 28a-f show Examiner must be notified ut	by Fu	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐Yes 2 ☐ N If Yes, Give Year or Dates:	lo	1 🗆 Yes	% No	Specify:				Specify:	Baltimo	ro
215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show the Medical Exeminetmust Le nuithed ut	edt	15. Decedent's E	ducation	16a.	Decedent's Usu	al Occup	ation			16b. K		ness/Industry	re
215	hin 72 an "na Me All	Completed	(Specify only highest gra	de completed) College (1-4or 5	+)	(Give kind of will life. DO NOT to	ork done ise retired	during most d)	t of workii	ng				
21	filed wit Hygiene other the	Con	10th	N/A		Sanitati	on						ce City	
nd	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last, Linwood Hi)	nes					r's Name lori	(First, Middle				
Maryland	ges 1 and 2 should be filed within 72 hi at of Health and Mental Hygiene. If item 27 is marked other than "natu or other treumatic event, the Medical	²	19a. Informant's Name/Relationship (10h	. Mailing Addres	s (Street				Ken		ate Zin Code)	
Ma	id 2 s Ith an 27 is p		Lori Hines-wife	1900, 171111)		501 Madi						timore		21217
	thealth tem 27 other tr		20a. Method of Disposition		20b. Place of	Disposition (Na y, crematory or	me of	ng)	D	ate	20c. L	ocation - Cit	ty or Town, Sta	ate
E O	Pages nent of I ont: If its		1 🖾 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif		Garri	son For	est	ΫA 1	/20/.	2005	Ow:	ings	Mills	MD
Baltimore,	permit. Pages 1 and 3 Department of Health Importent: If item 27 any injury or other tr once.		21. Signature of Funeral Service Licer	1500		22. Name a	nd Addre	ss of Facilit	y MA	RCH FUN	IERAI	L HOME	E-EAST	
<u>m</u>	8 9 E 8		1 M Rad	yo wo	ne	1101 E						re, MI		
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each lir	the death. Do note.	cp en 1		ng, such as	y I	TP	rrest,		interv	ximate al Between and Death
	Examiner	er	Sequentially list conditions,		Lmcn 1	of):							Uni	encun
	cuted	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	c										
30,	oe exe		resulting in death) Last	Due to (or as	a consequence	of):								
68760	cate b	dica		d										
P.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3□Ectopic p 5□ Other (s		y				23d. Date o Month		Year
	that ned by deta	y Pr	Part II. Other significant conditions	contributing to death b	ut not resulting is	n the underlying	cause giv	en in Part I.		23e. Did t	obacco	use contribu	ute to the caus	e of death?
Records,	v requires been sig should be		HIV/AIDS	\$						1 🗆	Yes 2	□ No 3[Probably	4 Adnknown
000	law requass been 2 shouk	Completed								24a. Was		24b. Wei	re autopsy find or to completio	dings available
Ä		E O								perfo 1 ☐ Yes	rmed?		ith? Yes 2 No	0
of Vital	ding Phyeicien: Th n. Affer this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Linguitali			0#			(Check only o				
of	Phyei this o	10	1 ☐ Yes 2 ☒No 27. Manner of Death	Hospital: 1 Inpatie						ne 5 🗌 Resi 28d. Describe			(Specify)	
O	After After	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da		njury M	28c. Injur Wor 1 □	rk? Yes 2 □:		.04. 2000/120		,, 00001100		
Division	al or Attending after death. I Director: After d in by the fune	Certification;	3 Suicide 6 Could not be determined	On Olega of Inc	ury - At home, fa c. (Specify)	irm, street, facto	ry, office		1	28f. Location (City or To			or Rural Route	Number,
	the Hospitel or Attenchin 24 hours after death the Eunerel Director: mpletely filled in by the	Medical C		nysician: To the best miner: On the basis of and manner sta	examination an									use(s)
	dwo.	Ň	29b. Signature and title of certifier		1 10			e number					Month, Day, Yo	
			> Ku Mart	- Medica	a) Kesi	2017	P	1765	00		90	our	1, 7, 7	2005
- (1			30. Name and address of person who Kn Stma May	completed cause of d	eath (Item 23a)	(Type, Print)	Reen	ve 54	Reet	BAL	timo	Re 1	1102	1201
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	Sept (5)								

DHMH 17 Rev 1/2001

	State of Maryland / Department of Health and Certificate of Death	Reg. No.
	Decedent's Name (First, Middle, Last)	1-0: (0:4
sician edical	Lollie Hockaday	January 13, 2005 11:40
ner	4a Facility Neme (If not institution, give street end number) 4b. City, Town, or	r Location of Deeth /4c. County of Death
	Result South Number 6 South 7 Age (In ure last hirthday) If Under 1 Year If Under 24 Hrs	S. 8. Date of Birth 9. Birthplace (State or Fo
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min	
	Usual Residence of Decedent	That Chapter That gran
	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Li 1 ∑ Yes 2 □
	Maryland N/A Bartmore 106. Zip Code	10g. Citizen of What Country?
	10e Street and Number 10f. Zip Code 10f. Zip Code	IJSA
-	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puel	(Specify Yes or No- orto Rican, etc.) 14. Race - American Indian, Black, White, etc.
l	Armed Forces? 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puer 1 Never Married 2 Married 1 Yes 2 No 1 Yes Sive 1 Yes 2 No 1 Yes 2 N	Specify: To 1
	3 ☑ Widowed 4 □ Divorced Year or Dates:	16b. Kind of Business/Industry
	15. Decedent's Education (Specify onfy highest grade completed) [Seedent's Usual Occupation (Give kind of work done during most of wo	
	Elementary/Secondary (0-12) College (1-4or 5+) Teacher	Balto. City Pub. S
	17. Father's Neme (First, Middle, Last) 18. Mother's Na	ame (First, Middle, Maiden Sumame)
	Ernest Hackett Cod	lare Smith
	INC. ALL FIG. P. T. LIVE DA. S. A. C.	Rural Route Number, City or Town, State, Zip Code)
	20a. Method of Disposition 200. Place of Disposition (Name of The Company)	Date 20c. Location - City or Town, State
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	1/25/2005 Owings Mills M
	21. Signard of Funeral Service Licensee 22. Name and Address of Facility	- J - Cwings minsp
	Monh & Kum Joseph L. Russ	S Funeral Home
_	23a. Pant / Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock or heart failure. List only one cause on each time.	iac or respiretory arrest, Approximate
		Interval Between
	Immediate Cause (Final disease or condition Mutastatic Endometral	
	Immediate Cause (Final disease or condition resulting in death) Autostatic Endomulation Due to (or as a consequence of):	
	Immediate Cause (Final disease or condition resulting in death) Autostatic Endomulation Due to (or as a consequence of):	
	Immediate Cause (Final disease or condition resulting in death) Autostatic Endomulinal Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	
	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Beguentially list conditions, death of the immediate and the properties to immediate and the properties and the properties are the properties are the properties are the properties and the properties are the prop	
	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	
i	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	Cancer
	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Due to (or as e consequence of): C	
	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as e consequence of): C	23b. Did tobacco use contribute to the cause of d
	Immediate Cause (Final disease or condition resulting in death) Autostatic Endomulinal Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying	23b. Did tobacco use contribute to the cause of d 1 Yes 2 No 3 Probably 4 Uni 24a. Was an autopsy performed? 24b. Were autopsy find available prior to completion of cause
	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	23b. Did tobacco use contribute to the cause of d 1 Yes 2 No 3 Probably 4 Uni 24a. Was an autopsy performed? 24b. Were autopsy find available prior to completion of cause of death?
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/ /	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Due to (or as a consequence of):	23b. Did tobacco use contribute to the cause of d 1 Yes 2 No 3 Probably 4 Uni 24a. Was an autopsy performed? 24b. Were autopsy find available prior to completion of caus of death? 1 Yes 2 Yes 1 Yes 2 No
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	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Due to (or as a consequence of):	23b. Did tobacco use contribute to the cause of d 1 Yes 2 No 3 Probably 4 Universal Property 1 Property 24b. Were autopsy find available prior to completion of caus of death? 1 Yes 2 Universal Probably 1 Yes 2 No Death (Check only one) 9 Home 5 Residence 6 Other (Specify)
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	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	23b. Did tobacco use contribute to the cause of d 1
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Medical Certification: To Be Completed by Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if erly leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): C	23b. Did tobacco use contribute to the cause of d 1 Yes 2 No 3 Probably 4 Uni 24a. Was an autopsy performed? 24b. Were autopsy find available prior to completion of caus of death? 1 Yes 2 Into 1 Yes 2 No Death (Check only one) 28d. Describe how injury occurred 28f. Location (Street and Number or Rurel Route Number City or Town, Stete) ace, and due to the cause(s) and manner as stated. courred at the time, date and place, and due to the cause(s)

			For State Registrar	State of Maryland		rtment of h			ene 005	01047
	Physici /Medio		1. Decedent's Name (First, Middle, Last Charles H	Henson	Vr.			2. Date of Death Month		71. 7 07 VIM
	Examir Funeral Director	er	4a. Facility Name (If not institution, give Baltimore VA 5. Social Security Number 212-58-1657 Usual Residence of Decedent	Medical Cente	t birthday)	D L	m C j C If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Feb, 15,		Antholace (State or Foreign outling)
	e Maryland 3a-f show Illied al	ctor	10a. State 10b. County	10c, City, T	own or Loc	don				10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	eath with th ne 23a or 26 must be no	by Funeral Director	10e. Street and Number 1 823 Bynur 11. Marital Status	n View Ct.	J	2/C	09		g. Citizen of What C	7
9036	iours after d ural', or item Leval, or	d by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	1	Yes, specify Cub	dispanic Origin? (Spi an, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or teme 23a or 28a-f show ent, the Medical Evary or most be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give k	ont's Usual Occup ind of work done O NOT use retire	during most of work	ng 10	6b. Kind of Business	industry tal
Maryland	should be file and Mental Hy marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) Charles H 10. Informatic Name/Polisticachie (Ti	Henson	Sr.	Address (Street	18. Mother's Name	a Mo	ie Ho	lden
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any Injury or other treumatic event, Ite Medical Evar. Let me the positived at once.		19a Informant's Name/Relationship (7)	Fowler 20b. Place come come	8/7 e of Disposi	tion (Name of atory or other plan	1 1/2/	St. T	Salto. Dc. Location - City of	Md. 21223
Baltimore,	permit, P. Departme Importent any Injury		1 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Ocens	L. Russ	/ Jo	ON FORE Name and Addre Seph. L	ss of Facility	Fuper e. Ba	wings al Hom	1111115/14a. 21216
	Prysician /Medical		23a. Parvi. Enter the disease, or comp shock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that cadsed the death. In the cause on each line. a. Probable Due to (or as a consequent)	hepai		kr Car			Approximate Interval Between Onset and Death
,0,	Examine be executed physician and the burlal-transit	Examiner	if any, leading to immediate cause. Eine, Underlying Cause (Disease or injury	b. Due to (or as a consequence. Due to (or as a consequence.	ice of):					
P.O. Box 68760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	ath 3 E	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	olivery Day Year
	w requires that s been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not resultin	ng in the und	lerlying cause giv	en in Part I.			o the cause of death?
al Records,		Completed		·				24a. Was an autopsy performe 1 Ves 2	prior to	utopsy findings available completion of cause of s 2 PNo
Vita	rsiclen: Th s certificate director, pag	To Be	25. Was case referred to medical examiner?	Hospital: 1 Minpatient 2 EP/	/Outpatient	3□ DOA Oth	26. Place of Death er: 4 \(\text{Nursing Hor} \)		na 6 □Othor (Sac	2006.)
Division of	Attending Physiclen: The in death, ector: After this certificate his by the funeral director, page		27. Manner of Death 1 Matural 5 Pending 2 Accident investigation		b. Time of Injury	28c. Injur Wor	y at k? Yes 2 □ No	28d. Describe how		City
DIVIS	P P P	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)				City or Town,		
×	To the Hospitel or within 24 hours after To the Funerel Dir. completely filled in It.	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exami	sician: To the best of my knowled ner: On the basis of examination and manner stated.	dge, death o and/or inve	occurred at the tir stigation, in my o	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
21	To the comp	M	29b. Signature and title of certifier	2		29c. Licens		-	. Date signed (Mont	
•			Ma	140			548	J _e	an 14,	, 2005
			30. Name and address of person who co Richard Ericson	mpleted cause of death (Item 23. $MD = 10 N_{\odot}$	Grpe, Pi	ne St	reet, B	altimore	e. 14n	21201
	Sta Registr	te ar	31. Date filed (Month, Day, Year) JAN 1 9 2005	32. Registrar's Signature	berte	5				,

DHMH 17 Rev 1/2001

			1 - For Stete Registrar	State of Maryland	d / Departn				ne 2005	. 0101.0
	Physic /Medi		1. Decedent's Name (First, Middle, Last)	Harri				2. Date of Death)ay 2.200	3. Time of Death
	Exami		4a. Facility Name (If not institution, give s Caltimore Kenabi Extended Care 5. Social Security Number 6. Sex	real and number) Tation and Lenter 7. Age (In yrs. ia		City, Town, or Salt	Location of Death MOTE If Under 24 Hrs.	8. Date of Birth	N/A	
	Funeral Director		-	M 2DF		nths Days	Hours Min.	(Month, Day, Yea FEB 18 19	(r)	lirthplace (State or Foreign Country) ARYLAND
	d 2 should be filed within 72 hours after death with the Maryland in and Mental Hyglene. 7 Is marked other than "natural; or Items 23a or 28a-1 show traumatic avent, it w Mulcal Expriner must be notified at	Director	10a. State 10b. County MARYLAND N/A	10c. City,	Town or Location					10d. Inside City Limits NXYes 2 □ No
	with the Sa or 2	Dire	10e. Street and Number 1027 CATHEDRAL	STREET APT 9		f. Zip Code	0.1		Citizen of What	Country?
	death	Funerai		2. Was Decedent Ever in U.S		212 Decedent of Hi	Spanic Origin? (Spec n, Mexican, Puerto P		.S.A.	nerican Indian,
36	s after , or Ite	by Fui	1 Never Married 2 Married	Armed Forces? 12⊈Yes 2 □ No If Yes, Give		, specify Cubai es 2 1 □ No	n, Mexican, Puerto P Specify:	ican, etc.)	Black, Wi	
21215-0036	hours tural;	ed b	3XXWidowed 4 □ Divorced 15. Decedent's Educ	Year or Dates:	16a. Decedent's			106		BLACK
215	within 72 iene. than "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	(Give kind of life, DO No	of work done d OT use retired,	uring most of working	9	Kind of Busines	ss/industry
21	filed with Hygiene. Ither than	Con	10th grade		LABORE	ER			AINTENC	Е
Maryland	ould be fii Mental H karked otl	Be c	17. Father's Name (First, Middle, Last)	TO			18. Mother's Name		en Sumame)	
aryl	and Men Is marke	으	JOHN WINFIELD HARF 19a. Informant's Name/Relationship (Typ		19b. Mailing Add	dress (Street a	ELLA BRO		or Town. State	Zin Code)
	C = 0 -		Nancy Robinson/Si	ster	525 DENI			rimore, m		
Baltimore,	of of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re		ace of Disposition metery, crematory	(Name of or other place	Da		Location - City of	
Him			' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Further Service (Specify)		RISON FO		01-21-	-05 OWI	NGS MIL	LS, MARYLAND
Ba	permit. Departr Imports any inj			410/1411	WILLI	AM C B	ROWN COMMUTH AVENUE	UNITY FUN	ERAL HO	ME P.A.
	Pnysician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, b.	ations that caused the death. Cancer Due to (or as a conseque	ESC	mode of dying	, such as cardiac or	respiratory arrest,	1	Appro imate Interv i Between Onset and Death
68760,	tificate be executed g physician and as the burial-transit	ledicai Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a conseque	ence of);					
O.	that the death certificate ed by the attending physidetached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3 □Ectop	oic pregnancy r (specify)			23d. Date of de Month	elivery Day Year
ords, P.	law requires tha as been signed 2 should be del	by	Part II. Other significant conditions contr	ibuting to death but not result	ling in the underly	ing cause giver	n in Part I.	23e. Did tobacco		to the cause of death? Probably 4 Dunknown
	The ate ha	Completed	25.44					24a. Was an autopsy performed? 1 ☐ Yes 2 ØN	prior to	
	Physician: r this certifica ral director. J	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Ho	spital: 1 ☐ Inpatient 2 ☐ El	R/Outpatient 3	DOA Other	26. Place of Death (Check only one) 5 Residence	6 Floates (6-	
ion of	Afte Afte fune	ation: T	27. Manner of Death 1		8b. Time of Injury	28c. Injury Work		d. Describe how inju		эспу)
É	ital or Attendurs after deathurs after deathurs all Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, fa	ctory, office	28	f. Location (Street a City or Town, Star		lural Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical	one)	rian: To the best of my knowless. On the basis of examination and manner stated.	edge, death occur on and/or investiga	ition, in my opi	nion, death occurred	d due to the cause(s at the time, date ar	s) and manner and place, and du	s stated. e to the cause(s)
	\$ 1 \$ 6 \$	7	29b. Signature and title of certifier	Tan, An. O),	29c License	4958	Jan	uary	4 2005
	Sta		30. Name and address of person who com AURO PA C TA 31. Date filed (Month, Day, Year)	pleted cause of death (Item 2	(Type, Print) LOCK	RAVE	NBOULEV	ARD, BAL	TIMORE,	ND 21218
	Registr		JAN 1 9 2005	Mine B.	poeres	P				

			State State Registrar	of Maryland / Depa	artment of Health		tal Hygien	- 0 0 0	01049
	Physici		1. Decedent's Name (First, Middle, Last) John	nsow		1 1 1	Date of Death Month D	ay Year /8, 200	3. Time of Death
	/Medic Examin		4a. Facility Name not institution, give street and		4b Sity, Town, or Location			c. County of Deat	
	Funeral Director		5. Social Security Number 6. Sex 216 - 34 - 8844 12M 2□ F	7. Age (In yrs. last birthday)	1 -1 -1	er 24 Hrs. 8. C	Date of Birth Month, Pay, Yea UEmbell) Gg	hplace (State or Foreign wintry) ARYANG
	death with the Maryland me 23a or 28a-f ehow crinist be ricitified at	tor	Usual Residence of Decedent 10a. State 10b. County MARY And BAH IMURE	10c. City, Town or Lo	ocation				10d. Inside City Limits 12 Yes 2 □ No
	3a or 28a	Funeral Director	10e. Street and Number 33333 KERRY ROP	11	10f. Zip Code 2 /2 0 7		10g. C	itizen of What Co	ountry?
36	or Ita	by Funera	11. Marital Status 12. Was D Ammed 1 Never Married 2 Married 1 Nover If Yes.	s 2 🗆 No	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 ☐ Yes 2 No Specif		Yes or No- n, etc.)	14. Race - Ame Black, Whit	
21215-0036	"na	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	d) (Give	dent's Usual Occupation kind of work done during mi DO NOT use retired)	-	16b.	Kind of Business	
and	should be filed within a Mental Hygiene. marked other than matic event, I to M	To Be Co	17. Father's Name (First, Middle, Last) HEN DERE HOWKE		18. Mot	ther's Name (Firs	st, Middle, Maide	n Sumame)	THEITER
, Maryl	nd 2 salth ar alth ar 27 le		19a. Informant's Name/Relationship (Type, Print) Sheila Johnson	19b. Mailir 33 3 20b. Place of Dispo		oad-lie	bodlawn	MARYLA	and 21207
Baltimore,	Page nent o ant: If ury or		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatuse of Funeral Service Licensee	om State BAHimore	· NAtional		2005 BA		MARyland
Ba	permit. Departr Importa any inje		23a. Part. Enter the disease, or complications the	e 34	ancy m. WACLA lost w. Frankli	ne tures	LALLANDER	nore, Mi	Approximate
•	Physician		shock, or heath ailure. List only one cause o	terrosclenstre				gia-	Interval Between Onset and Death Years
	/Medical Examiner	16	Due T	to (or as a consequence of): a sulin depend to (or as a consequence of):					Years
,	s be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Hy Due	pertention fo (or as a consequence of):					Years
68760,	fficate be exe g physician a as the burial-	edicai	d. <u>H</u>	yperlipidemic	r				Years
P.O. Box 6	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medicai	in the past 12 months?	egnant at time of death 5	□Ectopic pregnancy □ Other <i>(specify)</i>			23d. Date of dei Month	ivery Day Year
	9 P 9	ğ	Part II. Other significent conditions contributing to chronic renal insu		inderlying cause given in Par	rt J.	23e. Did tobacco		the cause of death?
Division of Vital Records,	The ate h page	Completed	Mesothelroma				24a. Was an autopsy performed? 1□ Yes 25N	prior to death?	topsy findings available completion of cause of 2□ No
Vita	ysician: The lis certificate hadirector, page	Be	25. Was case referred to medical examiner?		Othor	ice of Death (Ch		a = 0.11 (2-	-76.5
ion of	Attending Physician: or death. actor: After this certifica by the funeral director, I	ation: To	27. Manner of Death 28a. Da	□ Inpatient 2	11 3 DOX 4	28d.	Describe how inj	6 □Other (Specury occurred	city)
Divis	Hospital or Attend 24 hours after death Funeral Diractor; itely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Pla	ace of Injury - At home, farm, str illding, etc. (Specify)	reet, factory, office		ocation (Street a City or Town, Sta		ıral Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	ledicai C	(Check only 2 Medical Examiner: On the	the best of my knowledge, deat e basis of examination and/or in anner stated.					
•	To the within 2	M	29b. Signature and title of certifier	mo	29c. License numbe 0 3 5 8	44	Jane	ate signed (Monti	2005
1	5/10	T	30. Name and address 1 person who completed of D Roggen 5400 Ol	ause of death (Item 23a) (Type, d Curry Road 2. Fogistra's Signature	Print) Suite 108	Rand	lallstown	mo.	21133
	Sta Registi		31. Date filed (Month, Day, Year) 32 JAN 1 9 2005	. Ragistrar's Signature	parti				

		Places	Time or Drin	t in Bloo	le las	delible lule	C									
	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene															
		For Stata						nentai Hy	_	Z 1111.	01050					
		1 - Stata Registra MEND TTEM: 1. Decedent's Name (First, Middle, Las	#10d_PER_F	H G839	1/1	9/051EJH	Dealii	2. Date of De	Reg. No.		3. Time of Death					
Physicia	an		_{⁵″} bur Jackso					Month	Day							
/Medic		4a Facility Name (If not institution, give	o etroet and number)			4h City Town or	Location of Death	01	16	County of Des	in Baltimore					
Examin	er	Good Samorite	n Hospita	al		Baltim	ore			maryl						
Funeral Director		5. Social Security Number 6. S. 218-32-5346	DAM 2015	(In yrs. last bii 69	thday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da 01 20	th y. Year)	9. Bij	thplace (State or Foreign ountry)					
B		Usual Residence of Decedent														
urylar show	_	10a. State 10b. County		10c. City, Tow	n or Lo	cation					10d. Inside City Limits					
e Ma Sa-f s	Director	MD Baltimore	e	Baltim	ore	.,					1XX es 25/No					
iff th	- ic	10e. Street and Number	-			10f. Zip Code	_	8		zen of What C	ountry?					
23a	ā	5697 Purdue Ave.	. G4			2123	39 —————			USA						
permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Midical Examinar must be notified at once.	by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 N If Yes, Give Year or Dates:		If	Vas Decedent of H Yes, specify Cuba ☐ Yes 21x No	ispanic Origin? (Sp in, Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)		14. Race - Am Black, Whi Specify:						
tura tura		15. Decedent's Ed		16a	. Deced	ent's Usual Occupa	ation		16b Kir	nd of Business	/Industry					
in 72 n "na	Completed	(Specify only highest gra	ide completed)		(Give I		during most of work	_	100.11	19 01 03011000	· · · · · · · · · · · · · · · · · · ·					
with iene.	mo	Elementary/Secondary (0-12)	College (1-4or 54	+)		Truck D	river/Ope	CDL	т	ruckin	ď					
Hyg Hyg othe	BeC	17. Father's Name (First, Middle, Last)					18. Mother's Nam				3					
ld be ental Ked ic ev	ToB	William Jackson					Mattie .	Jacksor	1							
shou nd M mar	-	19a. Informant's Name/Relationship (7	Type, Print)	195	. Mailin	g Address (Street a	and Number or Rui	al Route Numb	er, City or	Town, State,	Zip Code)					
and 2 ealth a m 27 is		Gloria Waters/frie	end	56	97	Purdue A	Ave. G4,	Baltim	ore,	MD 21	239					
s 1 al f Hea item othe		20a. Method of Disposition	-	20b. Place o	f Dispos	sition (Name of		Date		cation - City or						
Pages nent of ant: If its ary or o		Name			-	Valley Me	1/44/	05 ardens	Time	onium	MD 21093					
artme orter injur		21. Signatura of Fuheral Service Licen		Datan	22	Name and Address	s of Facility									
permit. Departr Importe any inje		Bryan W. Cla			Le	emmon Fu D. W. Pad	uneral Ho Ionia Rd.	me of Timo	Dula: nium	ney Va . MD 2	lley, Inc. 1093					
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused one cause on each line	the death. Do						27 -0-2	Approximate Interval Between					
Physician		Immediate Cause Final disease or condition			050	lial in	farction				Onset and Death					
/Medical		resulting in death)	a. Due to (or as a	consequence	of):	(() ()										
Examiner			. Corono	ary A	rte	y olised	vse.									
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a			<u> </u>										
executed in and rial-transit	amin	Cause (Disease or injury that initiated events	C													
exe an a rial-t	EX	resulting in death) Last	Due to (or as a	consequence	of):											
eath certificate be exer attending physician ar for use as the burial-ti	cal		d													
tifica ag ph as th	ed															
andin use	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		2 [7]	Ectopic pregnancy			2	3d. Date of de	livery					
deatle e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at t			Other (specify)				Month	Day Year					
t the by th	Physician/Medical	9 🗆 Unknown	9□ Unknown													
s tha		Part II. Other significant conditions of	ontributing to death bu	t not resulting i	n the un	derlying cause give	en in Part I.	23e. Did t	obacco us	se contribute t	the cause of death?					
n requires that the deben signed by the should be detached	pe	End stage renal	discuse	on her	noc	lialysis		10	Yes 2]No 3 ☐ P	robably 4 @Unknown					
s bee	Set	Hypertension						24a. Was		24b. Were a	utopsy findings available					
The Is age 2	Completed by								rmed?	prior to death?	completion of cause of					
Attending Physicien: The law requires that the death certificate be rideath. octor: Atter this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the bur	O C	25. Was case referred to medical					26. Place of Deat	1 Yes	2 No	I L Yes	2 🗆 No					
/sicials s cert	To B	examiner?	Hospital: 1 Inpatien	ıt 2□ER/OL	Itpatient	3 DOA Othe				Other /Soc	city)					
y Phy or this oral c		27. Manner of Death	28a. Date of Injury	28b.	Time of	28c. Injury Work		28d. Describe								
nding th. : Afte	itioi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	rear)	njury											
Attending Physicien: or death. ector: After this certifica by the funeral director, p	ifica		e Olege of Injur	ry - At home, fa	ırm, stre	et, factory, office	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined determine									

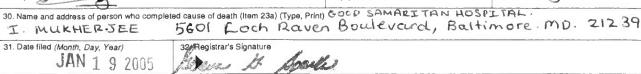
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.
To the Funcarel Director. After this certificate has been signed by the attending physician and completely filled in by the funcand director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Medical Cert State

31. Date filed (Month, Day, Year) JAN 1 9 2005

29b. Signature and title of certifier

29a. Certifier (Check only one)



M.D.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES 000

29d. Date signed (Month, Day, Year)

January 16

Registrar

			1- State of Ma	aryland / Depa <i>Cel</i>	artment of F			iene g. No.	5 01051
	Physici		1. Decedent's Name (First, Middle, Last) ANN INGRID	J	OHN		2. Date of Deat Month		
	/Medio Examir Funeral		4a. Facility Name (If not institution, give-street and number) 5. Social Security Number 6. Sex 7. Age	Life (In yrs. last birthday)	4b. City Jown, o	Location of Death	S Date of Birth	4c. County of E	Birthplace (State or Foreign
	Director		071-72-2604 1□ M 2XF Usual Residence of Decedent	47 Yrs.	Months Days	Hours Min.	7 3 1		cinidad
	Marylan a-f show	tor	10a. State 10b. County N/A	10c. City, Town or Lo Baltin					10d. Inside City Limits ★XYes 2 ☐ No
	with the 3s or 28s	i Director	10e. Street and Number 2527 E. Oliver Street		10f. Zip Code 212	213	1	0g. Citizen of Whal	Country?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23a or 28a-f show or other treumatic event, the Medical Exart must be rotified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes 2 V Married 1 Yes 2 V Married 1 Yes 7 V Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2√ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Specify	merican Indian, /hite, etc.
Maryland 21215-0036	d within 72 ho giene. sr than "natur the Mudicul	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5 N/A)	(Give	dent's Usual Occup kind of work done DO NOT use retired king Atte	during most of work d)	ing	16b. Kind of Busine	ess/Industry
and	ild be file lental Hy ked othe	To Be C	17. Father's Name (First, Middle, Last) unknown			18. Mother's Name Grace	e (First, Middle, A	aiden Sumame) Subra	an
Mary	id 2 should lith and Men 27 is marke treumatic		19a. Informant's Name/Relationship (Type, Print) Ali Sharhan-son			and Number or Run		-	
altimore,	Pages 1 and nent of Health int: If item 27 iry or other tr		20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo cemetery, crer		ca)		20c. Location - City	or Town, State
Baltii	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Service Licensee	22	2. Name and Addre		RCH FUNE	RAL HOME-	
8760,	Physician and Medical Examiner the burial transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unionitying Cause (Disease or injury that initiated events	10.	er the mode of dyin	4	or respiratory arre	est,	Approximate Interval Batween Onset and Death
.O. Box 68	The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year
<u>a</u>	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death by	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob		e to the cause of death? Probably 4 Unknown
al Records,		Completed	dystipidemia hemorrhade				24a. Was ar autopsy perform 1 Yes 2	24b. Were	aulopsy findings available to completion of cause of
Division of Vital	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funeral Director: After this certificate h. completely filled in by the funeral director, page	atlon: To Be	25. Was case referred to me dal examiner? 1 Yes 2 No 1 Hospital: 1 Inpatie 27. Manner of Death 1 Natural 5 Pending (Month, Day 2 Accident)	ry 28b. Time of	28c. Injun Worl	4 □ Nursing Ho		nce 6 Other (S	pecify)
Divis	al or Attendent after death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injuiding, etc.	ury - At home, farm, street. (Specify)	eet, factory, office		28f. Location (Str City or Town,		Rural Route Number,
PÍ	To the Hospital or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	examination and/or inv	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner te and place, and c	as stated. due to the cause(s)
	То th within То th сощр	Me	29b. Signature and title of certifier MEDI	CAL DOCTOR		-000		d. Date signed (Mo	onth, Day, Year) 14, 2005
			30. Name and address of person who completed cause of de SiGRID BERG, MD, TOHNS HOPKIN	IS HOSPITAL, (Print) ODNORTH	WOLFE STRE			
	Sta Registr	te	31. Date filed (Month, Day, Year) 32. Registra	ar's Signature				•	

DHMH 17 Rev 1/2001

			1 - For State of Mary		artment of Health		al Hygien	2005	01052
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Earnestine Kenion			М		ay Year L4 2005	3. Time of Death
	Exami		4a. Facility Name (If not institution, give street and number) Joseph Richey Hospice		4b. City, Town, or Location Baltimore	on of Death	2	c. County of Death	
	Funeral Director		5. Social Security Number 259-13-3999 Usual Residence of Decedent 5. Sex 1	yrs. last birthday) Yrs.	If Under 1 Year If Under Months Days Hour		ate of Birth fonth, Day, Year / 05 / 1959	1	place (State or Foreign ntry) gia
	ith the Maryland or 28a-f show	tor		c. City, Town or Lo					10d. Inside City Limits
	uth with the 23a or 28a ust be noti	al Director	10e. Street and Number 7311 Campfield Road	Pikes	10f. Zip Code 21208		10g. C	itizen of What Cour	ntry?
18	C 21215-0036 filed within 72 hours after death with the Maryland Hygiene thar than "natural", or Items 23a or 28a-f show ant, the Medical Exeminant has the mollihed at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispanic If Yes, specify Cuban, Mexi 1 ☐ Yes 2 ☐ No Spec		es or No- etc.)	14. Race - Americ Black, White,	
2/0	21215-0 within 72 ho iene. r than "natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usual Occupation kind of work done during n DO NOT use retired)	nost of working	Sc	Gind of Business/In hool systimore Co	tem
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Ŏ.	1,2 € d ≥		19a. Informant's Name/Relationship (Type, Print) Melvin Kenion / Husband	7311 (ng Address (Street and Num ${ t Campfield}$ ${ t Rd.}$				
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;	Balt permit. Departr Imports any inji		21 Signature of Funeral Service icensee	46	Name and Address of Fa	s. Ave.,	Baltimo	. Jon e s E re, <u>Mar</u> yl	and 21215
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Kenion	ate be executed ate be executed hysician and he burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a condition of the cause) Due to						
	h.C. BOX by that the death certific, ed by the attending pl detached for use as t	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pre 1 □ Live birth 2 □ R 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
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1,, 8	VISION OF VITAL Randing Physician: The reach. actor: After this certificate by the funeral director, pag	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No	2 ER/Outpatient 28b. Time of Injury		28d. De		6 ★Other (Specify ry occurred	Hospice
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	tha Ho nin 24 h tha Fui npletely	Medical	29a. Certifier (Check only one) 15 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	estigation, in my opinion, d	leath occurred at th	e time, date and	d place, and due to	the cause(s)
	To With	_	29b. Signature analytitle of certifier	\supset	D290	-		te signed (Month, L	
	Sta Registi		30. Name and address of person who completed cause of death (ANAMOARCA S HAVAY 31. Date filed (Month, Day, Year) 324 Registrar's Si	MP 82	I N. EUT	AW 57	BAUT	Mari	- MO2/2

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Pohly Kaufmann January 8, 5:10 P M 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 9039 Parkside Plaza *#*708 Silver Spring Montgomery 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 □ M 2 💢 F 93 Yrs. Director 138-40-6924 March 13,1911 Germany Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location s 23a or 28e-1 show ust be notified at 10d. Inside City Limits XXYes 2 □ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9039 Parkside Plaza #708 20901 or items 23a United States death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic evant, the Midligal Examination e filed within 72 hours after all Hygiene. I Hygiene. I other than "natural", or Iter Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□Yes 2 No Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Specify: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be file Health and Mental Hy Iem 27 Is marked oth Be Pohly Julius ဥ Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or othar trai once. Herbert W. Kaufmann / Son 9115 Sligo Creek Pkwy., Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1/10/05 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral and Cremation Services Stipllet Tollunam M00382 933 Gist Ave., Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Severe Mitral Regurgitation /Medical Due to (or as a consequence of). Examiner Congestive Heart Failure Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Pleural Effussions resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rmed? 2 X No 1 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 XNo Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury s after decreal Director: Aft 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai npletely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D47928 January 11, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lila Bahadori M.D.; 10301 Georgia Ave., Silver Spring, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

DHMH 17 Rev 1/2001

		1	For State Registrar	State of	f Marylar		artmen rtificat			and M	ental Hy	giene Reg. No.	005	i (01054
	sicia	n	1. Decedent's Name (First, Middle, Last Margaret M. Kratz					_			2. Date of De Month Januar	Day	2005	r	9:00 P M
	edica ımine		4a. Facility Name (If not institution, give Ellicott City Hea.			enter			Location of		Darrace		County of De Howa	ath	
Fune Direc				х] м 2[Х F	7. Age (In yrs. 87	last birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	Min.	8. Date of Bird (Month, Da NOV 1,	th ly, Year) 1917		Country)	e (State or Foreign
Maryland			Usual Residence of Decedent 10a. State 10b. County Maryland Baltimon	re	10c. Ci	ity, Town or Lo								10d.	Inside City Limits 1 ☐ Yes 2 💆 No
h with the	NI SANG	Funeral Director	10e. Street and Number 1227 Greystone Roa	ad			10f. Zip	Code 227				-	en of What ted S		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 271 is marked other than "natural", or Items 23a or 28e-f show in the contract of the contract		à	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da	2 X No	1	Was Deced f Yes, spec 1 ☐ Yes		spanic Orion, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	1	4. Race - Ar Black, WI Specify:		
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and 2 sho ealth and I m 27 is me			19a. Informant's Name/Relationship (T. Margaret Kratz-Am.		ughter		-				A Mary			, Zip Co	de)
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1-11	1	1	30. Name and address of person who can Rodolfo E. Fernan								Catan	01117	, 14F	711	20
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	Examin	er	Holly Hill			,			wsor					Balto.	
	Funeral		5. Social Security Number	6. Sex		7. Age (In yr	s. last birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da	h	9. Birth	place (State or Foreign intry)
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	within 24 hours a To the Funerel I completely filled	edical (29a. Certifier 1 Cert.	fying Phys	sicien: To th	e best of my k	nowledge, death	h occurred	at the tim	e, date an	d place, a	and due to the	cause(s) a	nd manner as	stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registramend ITEM #468106 PER PHYSEH CESTIFICATE PARTIES Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death EUGENE W. LEAKE, JR Month () 1 **Physician** 7:00 PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Baltimore HARFORD 3423 Turner Road Monkton 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Months Days Hours 1XM 2□ F Yrs Director 049-16-1903 93 31.1911 New Jersev Usual Residence of Decedent with the Maryland 10a State 10b. County HARFORD 10c. City, Town or Location item 27 is marked other than "naturel", or items 23a or 28e-f show other treumatic event. The Medical Evantral must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director MD Baltimore Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3423 Turner Road 21111 or items 23a United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 No 43-46

If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. is marked other than "naturel", or ite 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Fine Arts Elementary/Secondary (0-12) College (1-4or 5+) Artist 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 is marked any injury or other treumatic evone. Eugene W. Leake Marion Paige 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nina Richardson/ Daughter 1516 34th St. N.W. Washington, D.C. 20007 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Jan 18, 2005 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Beltsville, MD 4 □ Donation 5 □ Other (Specify) Chesapeake Crem. 21. Signature of Funeral Service Licensee, M00986 22. Name and Address of Facility.
Cremation and Funeral Alternatives
8717 Green Pastures Dr. Baltimore, w 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Anen monits /Medical Due to (or as a consequence of): Examiner Oso Ahara Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner The law requires that the death certificate be executed burial-transit STOKE and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, iding physician Physiclan/Medical as the l 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sostate Cancer 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed res 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: "within 24 hours after death.
To the Funerel Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death Check on sone Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) - 42129 January 7002 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 21212 D. McConnell, N. Charles Sh MD 6301 32 egistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

JAN 1

9 2005

Physic	ian	1. Decedent's Nam Thomas I	ne (First, Midd						2. Date of D	eath Da		3. Time of D
/Medi Exami	cal		'If not institution	n, give street and nu Avenue	mber)			or Location of Dea	Januar	40	c. County of De	eath
Funeral		5. Social Security N	Number	6. Sex		s. last birthday,	Landsdow If Under 1 Year Months Days	If Under 24 Hrs Hours Min	s. 8. Date of B.	irth	Baltimo	lirthplace (State or I
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Maryla a-f show	tor	Md.	Balti			City, Town or L Baltimo						10d. Inside City
or 28	Direc	10e. Street and Nu	ımber				10f. Zip Code			10g. Ci	itizen of What (Country?
8 238	rai	2829 Ter	nessee					21227			USA	
be lied within 72 nouts atter death with the Maryland Hygiene. d othar than "natural" or Items 23s or 28s-1 show evant, the Modical Eventiner must be notified at	by Funeral Director	11. Marital Status 1 Never Mari 3 Widowed		ried Armed Fo	2 X No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Hispanic Origin? (San, Mexican, Puel Specify:	Specify Yes or N rto Rican, etc.)	10-	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White
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giene.	Completed	Elementary/Second 12		College (*	1-4or 5+)	Wait	DO NOT use retired	d)	nuing]]	Retail	Food
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	0		Decedent's Nam	ne (First, Middl	e, Last)								2. Date of D Month		lav	Voor	3. Time of D	eath
	Physici /Medic		Steve	en Mattl	hews								Januar	y 1	Ö, :	2005	20:05	М
	Examin		4a. Facility Name (ımber)			4b. City, Town,				4	c. Count	ty of Death		
	3		541 West								ltim					N/A		
	Funeral Director		5. Social Security 1 229-31-87	710	6. Sex	M 2□F	7. Age (I	n yrs. last bil	Yrs.	If Under 1 Year Months Day			8. Date of B (Month, D June 20	irth la <i>y, Y</i> ea D , 1	968		place (State or I ntry) .zonia	-oreign
	and		Usual Residence of	10b. County			10	Oc. City, Tow	m or Loc	ation							Od. Inside City	Limits
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other treumetic event, the Medical Examinar must be notified at once.	Funeral Director	Maryland		N/A				-	ltimore							1 x XYes 2	
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	Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one)	1☐ Certifyin 2☐Medical	g Physic Examine	er: On the b	e best of m easis of exi oner stated	amınation an	dor inve	occurred at the stigation, in my	time, date opinion, d	and place, a leath occurre	and due to the ed at the time,	cause(s date ar	s) and mand place,	anner as st and due to	ated. the cause(s)	
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		1)	hing h	, ئر ,	mid					C.M.I			Janu	ary	11, 2	2005	
	611		30. Name and add	ress of person	who com	pleted caus	se of death	n (Item 23a)	(Typę, Pr	int)					- 70			
	1		30. Name and add	ING	LI,	miD)		111	Penn St	reet,	, Balt	imore,	Mar	ylar	nd 212	201	
	Sta Registr		31. Date filed (Mor	JAN 1	9 20	32. F	Registrar's	Signature	· A	bark								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Marecki 16,2005 ANUALY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Horkins HIMORE 1 Year If Under 24 Hrs. N/A JOHNS 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Country)
NOV. 23,1916 MARYLAND Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 1□M 2MF Days Hours 212-10-4805 88 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 234 S. CHAPEL STREET 21231 U.S.A. 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 ☑ No 3 ☐Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WALTER KRATZ STELLA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOSEPHINE MACH/NIECE 7904 DIEHLWOOD RD DUNDALK MARYLAND 21222
se of Disposition (Name of Date Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Mathod of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ST. STANISLAUS CEM. 1/20/05 BALTIMORE, MARYLAND ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
LILLY & ZEILI LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, April 1901 April 1901 East 1901 Eas 21231 Approximate Interval Between Onset and Death Immediate Cause (Final 1 month Adult Plap ratery Due to (or as a consequence of): Distress Syndrame disease or condition resulting in death) Primococca imouth Due to (or as a consequence of) 5.treptucoccol
Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year 4☐Pregnant at time of death Month Day 5 Other (specify) 9 Unknown 9 Unknown

Physician /Medical Examiner

use as the burial-transit

the attending physician

signed by the

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After

within 24 hours after death. To the Funerel Director: A

certificate be executed

Box 68760

P.O.

Records,

Division of Vital

To the Hospitel or Attending Physicien:

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Important: If ite
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s 1 and 2 should be filed within 7 if Health and Mental Hygiene.

Director

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the Maryland

72 hours after

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I loastoin testinal bleed 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

rep vein thrombosis 25. Was case referred to medical examiner?

investigation

6 ☐ Could not be

autopsy 2 No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

1 Yes 27. Manner of Death 1 Natural 5 Pending

2 Accident

3 Suicide

4 \ Homicide

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No М

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Death (Check only one,

29b. Signature and title of certifier,

29c. License number RES-000

29d. Date signed (Month, Day, Year, January 14, 2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Svác S. Sutton, 31. Date filed (Month, Day, Year)

Street, Tour 110, Bultimore, maryland 21287 GOO North Wolfe 32. Registrar's Signature 9

MA

Registrar DHMH 17 Rev 1/200 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ž05 Kobert Miller 0100 Am Bathmore

Arri Year | If Under 24 Hrs. | 8. Date of Birth Hours | Min. Aug 2, 1941 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Mercy Center NIA Medical 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1፟፟፟∭M 2□F Months Yrs. 63 Director 215-40-9348 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other treumatic svent, the Medical Exampler must be motified at Yes 2 No Baltimore MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 W. Franklin Street 21202 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No U.I If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married unk Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "na any injury or other treumatic svent, I an Media once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Be unk မှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mercy Medical Center 301 St. Paul Place Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 Donation 5 NOther (Specify) ins tate State Anatomy Board 655 W. Baltimore Street Signature of Funeral Service Licensee Baltimore, MD 21201 Part1. Enter the dis se, or com hock, or heart failure. List only plactions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acquired Immunodeficiency Syndrome **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of): **Examiner** Myeloma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physicien: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Renal Disease Stage Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Phelimonia 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown Completed this certificate has been Anemia 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 2[] No 1 Yes 1 Tyes Director: After this certific t in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 (C Natural 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospitei within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 17668 01/08/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 301 St. Paul Place C. HUYNH, MD

DHMH 17 Bev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1

9 2005

Carre

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician January 16 2005 ear 8:33 A M Vernon Thomas Palermo /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8412 Allison Lane Baltimore County Baltimore 7. Age (In yrs. last birthday). 5. Social Security Number 218 28 1828 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1**X**☐M 2☐F Director Yrs. December 26 1932 Baltimore, Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
snt: If item 27 is marked other then "naturel", or items 23e or 28e-f show ury or other treumatic event, I'm Marical Exarchest master profiled at 1 ☐ Yes 2 X No Be Completed by Funeral Director Baltimore Baltimore County Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 21237 8412 Allsion Lane 12. Was Decedent Ever in U.S. Agned Forces? 1 ①Yes 2 □ No If Yes, Give Year or Dates: **Korea** 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes XX No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) American National Can Co. Lithographer 18. Mother's Name (First, Middle, Maiden Sumame) Emily Keng 17. Father's Name (First, Middle, Last) Louis Palermo Emily 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Denise Gajewski (Daughter) 5410 McCormick Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial XX Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or once. Metro Crematory Inc. January 19 2005 Baltimore, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Marylanu 21236 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Matha Joseph Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** esophageal /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): the attending physician Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy should be detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy performed? Yes 2 No this certificate 1 ☐ Yes or Attending Physicien: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred : After t 5 Pending investigation 1 Natural Injury death. 1 Yes 2 No 2 Accident after death completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Fo the Hospitel within 24 hours a To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40854 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Riseberge. St Parl 301 Durch MD 21202 31. Date filed (Month, Day, Year) 2005 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O.

		1- State of Maryland / Department of Health and N Certificate of Death	/lental Hy	-	005	01000
		Decedent's Name (First, Middle, Last)	2. Date of De	Reg. No	.000	3. Time of Death
Physici /Medi		Alma Lydia Price	Jan.	Day 10	2005	2:20p ^M
Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death			unty of Death	Σ.20ρ
		Gilchrest Center for Hospice Care Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.			timore	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) Yrs. Months Days Hours Min.	8. Date of Bir (Month, Da	ay, Year)	9. Birthp Coun	lace (State or Foreign try)
D		Usual Residence of Decedent	03/23/	1931	Mar	yland
arylan show	_	10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
Ba-f:	Director	MD Harford Havre de Grace				1 Yes 2 □ No
with t	吉	10e. Street and Number 10f. Zip Code	i	_	of What Coun	itry?
Jeath ns 23	by Funeral	604 North Adams St. 21078 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.	acity Vas or No	USA	Race - Americ	an Indian
after or Iter	Fun	Armed Forces? If Yes, specify Cuban, Mexican, Puerio	Rican, etc.)	, 14.	Black, White,	
DO3	d by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:		Sp	ecify: Wh	ite
15-(172 h	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	ing	16b. Kind	of Business/Inc	lustry
withii ene.	dmc	Elementary/Secondary (0-12) College (1-4or 5+) 10th College (1-4or 5+) Bus Driver		C - l	-1	
Ind 21215-0036 be filed within 72 hours after death with the Maryland lat Hyglene. d other then "nature!", or tems 23s or 28s-f show event, the Medical Exalt the tuntiles is withing at	Be C	17. Father's Name (First, Middle, Last) 18. Mother's Name	e (First, Middle	Scho Maiden Sui		
Vlar uld be Jenta riked tic ev	10 B	William Henry Neff Lydia E	Hadle	·V		
ore, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If health and Mental Hygiene. If the marked other then "naturet", or items 23a or 28a-1 show other treumatic event, the Medical Examinations and Lease of the Landon.	ľ	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run			wn, State, Zip	Code)
S, N and and leath m 27		Susan Price- Daughter 604 N. Adams St., Ha				
altimore, mil. Pages I ar partment of Hear portment of Hear portant: If item y injury or other		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Locati	on - City or To	wn, State
Itim It. Pa rtmen rtant:		'4 □Donation 5 □Other (Specify) Angel Hill Cem. 01/1	4/05	Havre	de Gr	ace, MD
Baltimore, Miporenti. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tre		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Smith Fune 123 S. Washington,	ral Hon Havre	ne, P. de Gi	A. cace, M	ID 21078
		23a-P4n1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory a	rrest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death) a. LVVg Cancer				Onset and Death
/Medical Examiner		Due to (or as a consequence of):			1	
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
uted d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
60, be executed ician and burial-transit		resulting in death) Last Due to (or as a consequence of):				
ate ate	dical	d				
	Med	IF FEMALE:				
1/10/05 2.30 pm. IRecords, P.O. Box 61. The law requires that the death certific ten has been signed by the attending plage 2 should be detached for use as a	by Physician/Me	23b. Was decedent pregnant in the past 10 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy			Date of deliver	y Day Year
P.O. that the de by the delached	ysic	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			To the total of th	7 6d;
S, P.	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use o	ontribute to the	a cause of death?
Records, he law requires to has been signegge 2 should be	leted b		101	/es 2□N	3 ☐ Proba	ibiy 4 Unknown
Recording law requires been ge 2 should	plet		24a. Was		b. Were autop	sy findings available
	Comple		autop perfor	rmed? 212 No	prior to com death? 1 \(\sum \text{Yes} \)	pletion of cause of
of Vital Physicien: The this certificate	Be (25. Was case referred to medical examiner? 26. Place of Death	(Check only o	ne)		
This hy	2	1 ☐ Yes 2√3 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hor	me 5□Resid	lence 6 K	ther (Specify)	nospige
PRECO	tlon	1/Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe h	low injury oc	curred	
14 P.P. Division I or Attending after death. Director: After	flca	3 Suicide 6 Could not be 28e Place of Injury - At home farm street factory office	28f. Location (S	Street and Nu	mber or Ruml	Route Number
Div Div al or A	Certification:	4 Homicide building, etc. (Specify)	City or Tow	m, State)	moor or marar	riodie ivaniber,
Hosp Hosp 4 hours Fune	edical (29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, a constant of the construction of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the dead at the time, d	cause(s) and date and plac	manner as sta	ted. the cause(s)
T := T O	Me	29b. Signature and title of certifier 29c. License number			ned (Month, D	
D W 2		My 1911 Jun DERSOS	(JANUM	4 10	2002
a Bro		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMON J. HALUS W. (1601 V. Charles St. 1	Baltu	100 1	ND 512	04
Stat	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		U UC V		
Registra		JAN 1 9 2005 See & Species				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 788 tate of Maryland Copartment of Health and Mental Hygiene 1- State Registrar AMEND ITEM #20a-c PER FH G83 Gertificates of Peath 2. Date of Death 3. Time of Death **Physician** Month John Wesley Preston January 13, 2005 1:45 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baker Circle Apt. D Edgewood Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth 3-1-1954. Birthplace (State or Foreign Months Days Hours Min. Month, Day, Year) MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** M 2□F Months 50 47 217-60-1850 Director Usual Residence of Decedent the Maryland 10a. State 10b. County Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Harford Director Edgewood 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5210 Baker Circle Apt. D 21040 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1. Never Married 2 Married 1 ☐ Yes 2 ₹ No If Yes, Give Year or Dates: ö 1 Yes 2 No ģ Specify: 3 Widowed 4 Divorced Specify: Black "naturel" Completed other treumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Domestics Elementary/Secondary (0-12) 1 0 College (1-4or 5+) Cleaning . Pages 1 and 2 should be filk Iment of Health and Mental Hy tant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Wesley Preston Lavinia Elizabeth Preston 9 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sam Preston/Brother 6210 Baker Circle Apt. D Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of Commetery, crematopy or other place) Date UNK 20c. Location - City or Town, State UNK Jan20, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ° 4 ☐ Donation 5 Other (Specify) UNK he superke Le 21. Signature of Funeral Service Licensee M00984 22. Name and Address Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic colon comces year /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical esn IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) Day ☐ Yes 2 ☐ No the Ö 9 Unknown 9 Unknown ģ ئە Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate Division of Vital 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospitel or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) 01-14-2003 maelain M.D D45530

State

Preston, John

31. Date filed (Month, Day, Year)

S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Believe.

SUITE 200, ATWOOD ROAD BELAIR ND 21014 32 registrar's Signature

JAN 1 9 2005

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Veer <u>01:4</u>7 a ^M MYRLEENE January /Medical R. PERRY 11 2005 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE
If Under 1 Year If Under 24 Hrs. HARFORD CO 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) APRIL 20 1935 **Funeral** Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Days Hours Yrs Director 69 NORTH CAROLINA 237-50-0237 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 ☐ Yes 2 🔯 No MARYLAND HARFORD CO ABERDEEN 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or Itams 23a 115 SPESUTIA ROAD 21001 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2000 À Specify: BLACK 3XXWidowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than ' Elementary/Secondary (0-12) College (1-4or 5+) 12th grade HOUSEWIFE/DAY CARE PROVIDER SELF 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fil tment of Health and Mental H tant: If itam 27 Is markad ott Be EDDIE RICHARDSON MYRTLE YOUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vickie Johnson/Daughter 115 Spesutia Rd., Aberdeen, Md., 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2x Cremation 3 ☐ Removal from State ō `4 □ Donation 5 □ Other (Specify) METRO CREMATORY 01-15-05 BALTIMORE, MARYLAND 21. Signature 22. Name and Address of Facility WM C BROWN COMMUNITY FUNERAL HOME-HARFORD, P.A. Scoum 321 S PHILADELPHIA BLVD., ABERDEEN, MD 21001 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician OFemany /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury physician and the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Division of Vital 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 HNO 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ 100 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After tha Hospital or Attending hin 24 hours after death. 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours at To tha Funaral D completely filled it 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11/05 71606(

Registrar

60)

S. Union ave-

Was ulocke MD 21074

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

23

NAIR

MD

32 Registrar's Signature

KORMA

31. Date filed (Month Day, Year) 2005

			1 - For State Registrar	State of Maryla			Health a	nd Mental H		ริกกร	01065
			Decedent's Name (First, Middle, Last)					2. Date of I		6.	3. Time of Death
	Physici		Fred		P	ierorazi	0	Janua	ry 18		12:20A M
	/Medic Examir		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town,			-	c. County of Death	12.20A
			309 German Hill Ro	ad		Dund				Baltimore	
	Funeral		Social Security Number 6. Sex		rs. last birthday)	If Under 1 Year	If Under 2		Birth		ice (State or Foreign
	Director		175/12/5903	M 2□F	84 Yrs.	Months Days	Hours	August	Jay, Year, 5 19	20 Countr	ice (State or Foreign y) Italy
	2		Usual Residence of Decedent					-1,0,000			reary
	anylar	_	10a. State 10b. County	10c.	City, Town or Lo	ocation				100	d. Inside City Limits
	Ba-f	Directo	Maryland Baltimore	2	Dunda1	k					1 □ Yes 2 □ No X
	or 2	- Sec	10e. Street and Number			10f. Zip Code			10g. Ci	itizen of What Countr	y?
	ath w	ra	309 German Hill Ro			212:	22			U.S.A.	
	or de	Funeral	11. Marital Status	2. Was Decedent Ever in Armed Forces?	14.S. 13.	Was Decedent of I	Hispanic Origi an, Mexican.	n? (Specify Yes or N Puerto Rican, etc.)	10-	14. Race - American Black, White, et	n Indian,
36	orl	by F	1 Never Married X Married	1 ∑XYes 2 ☐ No If Yes, Give 1 (- / F	1 ☐ Yes 2 🛣 No				Specify: Whi	
5-0036	be illed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or iteme 23s or 28s-f ehow event, I'm Medical Examinal must be notified at	å g	3 Widowed 4 Divorced	Year or Dates:						Opening. Will	
꺗	"nat	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Occu _l kind of work done DO NOT use retire	pation during most of	of working	16b. K	Kind of Business/Indu	stry
7	withii ene. than	ם	Elementary/Secondary (0-12)	College (1-4or 5+) NA					D .	11 1 0.	
2	filed Hygid other		17. Father's Name (First, Middle, Last)	NA	FORK	Lift Open	1	s Name (First, Midd		hlehem St	eel
Maryland 2121	d la b	Be	Genoeffo		Pierora	zio.	Josep		e, Maider	_	
2	should nd Men marke	ဥ	19a. Informant's Name/Relationship (Type						4 00	Campai	
<u>8</u>	2 6 9 5			(Son)						or Town, State, Zip C	ode)
	1 and 3 Health tem 27 other tr		Fred Pierorazio 20a. Method of Disposition		. Place of Dispo	Pimlico	Court	Forest Hi		Md. 21050 ocation - City or Town	- 6
altimore,			1 Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, crei	natory or other pla	, ,	January		-	
	it. Pi		'4 □ Donation 5 □ Other (Specify)		acred H	eart of J	Jesus 2	20,2005	Dun	dalk, Mary	yland
Ba	permit. Page Department Important; II any Injury or once.		21. Signature of Funeral Service License		O . \Box	W. Dabro	owski/C	Choinacki	Fune	ral Homes	РΑ
Ė			Jah C.	ropert	re'	1005 Dunc	talk Δυ	re Roltin	Oro	Maryland	21224
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	cause on each line.	ath. Do not ent	er the mode of dyli	ng, such as ca	ardiac or respiratory	arrest,	Ir	pproximate nterval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	petastatic	aderrica	necrepy	Marter	lun 1	runo		Inset and Death
	/Medical Examiner		resolving in dealth)	Due to (or as a cons	equence of):					J	
			Sequentially list conditions, b.	He services and the							
	pe isi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a cons	equence or):						
	and I-tran	кап	that initiated events resulting in death) Last	Due to (or as a cons	20110000 04)						
3/60,	cate be executed physician and the burial-transit			Due to (or as a cons	equence on.						
	physicate sthe	dlcal	d.								
×	death certificate e attending phys d for use as the	hysiclan/Me	IF FEMALE:	a If you outcome of acor							
X P P	atten for us	lan	23b. Was decedent pregnant in the past 12 months?	 c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 	etal death 3	Ectopic pregnancy	у		141	23d. Date of delivery Month Date	ay Year
o.	the de	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time o 9☐ Unknown	tdeath 5∟	Other (specify) _				World De	ay roat
J.	that the de ned by the a detached f	۵.	Part II. Other significant conditions cont	ributing to death but not r	aculting in the u	adosh dan assure ass	i- D- 41	One Did			
Š	e be	by	Tatti. Other signmeant contactors cont	induting to death but not i	esulting in the ur	ideriying cause giv	en in Parti.			use contribute to the	
ecords,	w requir been s should	etec						_ '	Yes 2	NO 3∐Probab	ly 4 □Unknown
ပ္	law lasb	Completed						24a. Wa auto		24b. Were autopsy prior to comp	findings available letion of cause of
	The page	Co							ormed?	death?	≥ No
VII	scontificate has birector, page 2 s	Be	25. Was case referred to medical examiner?					Death (Check only	one)		
0	Physician: r this certifice real director, p	P	1 ☐ Yes 2 ဩXNo		☐ ER/Outpatien	t 3□ DOA Oth	er: 4 ☐ Nursi	ng Home 5 🖾 Res	idence	6 ☐Other (Specify)	
	ding P h. After t funera	on:	27. Manner of Death 1 XNatural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at k?	28d. Describe			
VISION	Attendil death. ctor; A: y the fu	Certification:	2 Accident investigation			M 1 🗆	Yes 2 □ No				
Ë	I or Atten after deat Director; I in by the	Ĕ	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe.	home, farm, stre	et, factory, office		28f. Location City or To	Street an wn, State	d Number or Rural R	oute Number,
2	ital c										
	Hosp thor une	edical	29a. Certifier 1 ☐ Certifying Physi- (Check only 2 ☐ Medical Examine	cien: To the best of my k	nowledge, death	occurred at the tin	ne, date and p	place, and due to the	cause(s)	and manner as state	ed.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		,	and manner stated.				occurred at the time	date and	pace, and due to the	e dause(s)
	To with	Σ	29b. Signature and title of certifier	74 " - 0		29c. Licens	,			e signed (Month, Da)	
			m. lintel &	rell Wester	an	019	714		Janu	uary 18,20	005
	YIN	1	30. Name and address of person who com	pleted cause i death (It	em 23a) (Type, I	Print)		Λ.		1	
الريا			MILYGEL FURTELL	UHSVMC	- 4940	12.4Me1	ar AV	e BALTII	LOR	Mrizz	4
	Stat		31. Date filed (Month, Day, Year) JAN 1	32. Registrar's ag	nature	1 1	£ 5				
	Registra		3.43 [1]	VI [711] ■ 5%9.	Maria P	· Annas					

05-00293 John Roche RJD

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Physicia /Medica	al	John Patrick Ro								January			0506A	• M
Examine		4a. Facility Name (If not institution, give)		46. City, Park		Location of	of Death		4c. County Baltin			
9		24 Sylvan Park Dr 5. Social Security Number 6. S		ge (In yrs. las	st birthday)			e If Under	24 Hrs.	8. Date of Birth	1		place (State or	Foreign
Funeral Director			DM 2075	45	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, July 13	1959	MD	place (State or ntry)	roraigir
) p		Usual Residence of Decedent		140- 0:	*									
shov ed al	5	MD Balto.			Town or Lo	cation							10d. Inside City 1 ☐ Yes 2	
the N	Director	10e. Street and Number				10f. Zip	Code			10	g. Citizen of V	Vhat Cou		
3a or	0	24 Sylvan Park	Ct.				2123	36			3 , -	USA	•	
death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Deced			gin? (Spe	ecify Yes or No- Rican, etc.)			can Indian,	
36 after or its	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🔀 If Yes, Give	No		1 ☐ Yes		Specify:	1, 1 46110 1	riioari, etc.)	Specify		hite	
hours tural	g pe	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1	16a. Deced			ition		4	6b. Kind of Bu			
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aryland 21215-0036 should be filed within 72 hours after death with the Maryland of Menial Hygiene. It marked other then "natural; or items 23a or 28a-f show umatic event, the Medical Examinar must be notified at	င္	James Kemp Roc								L. Lap				
01 00 00		19a. Informant's Name/Relationship (** Leslie Ann Roche								≀Route Number, *mont, N	-		Code)	
Hea Hea	1	20a. Method of Disposition	/ WIIC		ce of Dispo				1/17		0c. Location -		own, State	
Pages nent of Hant or of hange of ha		1 Surial 2 Cremation 3 C 4 Donation 5 Other (Specification)		, ,						/05 ardens -	Cimoniu	ım. I	MD 210	93
Baltimore, permit. Pages 1 ar Department of Heal Importent: If them any injury or othe once.	I	21. Signature of Funeral Service Licen	98	, =										
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Boath death atternation	clar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal de	eath 3	Ectopic processes of the second secon					23d. Date Mor		Day Ye	ar
P.O. that the de det by the detached	hys	9 Unknown	9□ Unknown											
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BCOF	Completed									24a. Was an autopsy	24b. V	Vere auto	psy findings av	/ailable
The I	E O									perform	ed? d	eath?	2□ No	
f Vital Bysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				0.5			(Check only one				
Of Physical direction	ို	1X Yes 2 □ No 27. Manner of Death	I 🗀 Inpatio		Outpatien Bb. Time of			4 🗆 140	-	ne 5 ☐ Resider 28d. Describe hov			y) (scene	e)
On on ding P. After funer.	t on	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ay Year)	Injury	м	8c. Injury Work 1 🗀 \	? ′es 2 🔲 I		iga. Bosonibo not	rinjury occurre	Ju		
Division or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be determined	9 28e. Place of In	jury - At hom	e, farm, str	eet, factory	, office		2	28f. Location (Stre		ar or Rura	l Route Numbe	9 <i>r</i> ,
Div tel or s afte el Dir	Cert	4 Holincide	building, et	tc. (Specify)						City or Town,	Siale)			
DIVI To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying Ph (Check only one) Medical Exam	ysician: To the best niner: On the basis o and manner st	of examination	edge, death n and/or inv	occurred vestigation,	at the tim	e, date an inion, dea	d place, a th occurre	and due to the cau ad at the time, dat	ise(s) and mai e and place, a	nner as si	ated. the cause(s)	
To the transfer of the transfe	Ž	29b. Signature and title of certifier	1000	Λ			C.M.	number F.			d. Date signed			
V (Kill)	2	· Caroll	allan	wa			J.111				aridar y	,		
10/18		30. Name and address of person who	UANN	rd		11		enn St	t., E	Baltimore	e, Mary	land	21201	
Stat Reg istra		31. Date filed (Month, Day, Year)	32. 35/6 41	rar's Signatur	y A	mile	Ŷ							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year Michelle Anne Ringo /Medical 14, 2005 January 7:55 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 10428 Haywood Dr. Silver Spring Montgomery 5. Social Security Number II Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🏋 F 37 Director 220-80-8119 Nov. 22, 1967 New Jersey Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location ral', or Items 23a or 28a-f show Example must be notified at 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10428 Haywood Dr. 20902 United States Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "natural", or Items 23.
ury or other traumatic event, the Medical Exactional and Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2X No White þ Specify Specify: 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Contract Negotiator Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ringo Robert Ralph Bree Fary f.k.a. Janice E. Zimmerman 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bree Fary / Mother 3550 Big Pine Rd., Melbourne, FL 32934 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. Chesapeake Crematory 1/15/05 Beltsville, MD 22. Name and Address of Facility Rapp Funeral and Cremation Services Dohnwan M00382 933 Gist Ave., Silver Spring, MD 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
4 yrs. 7 mth Immediate Cause (Final Priysician Metastatic Breast Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence ol) Hospitel or Attending Phyeiclan: The law requires that the death certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2XXVo Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 X X atural investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, Iarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37236 January 14, 2005 30. Name and address of per son who completed cause of death (Item 23a) (Type, Print) Carolyn B. Hendricks M.D.; 6410 Rockledge Dr. #625, Bethesda, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) Section . Registrar JAN 1 9 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per phy G839 1-19-05, tas per phy G839 1-19-05, tas per phy G839 1-19-05, tas per phy G839 1/26/05 JH Reg. No. Reg. No. Reg. No. Pecedent's Name (First, Middle, Last) Control of Death Reg. No. Reg. Reg. No. Reg. Reg. No. R 1. Decedent's Name (First, Middle, Last) Gordon E. Rent Sr. 3. Time of Death Month Yeer 5:00 A M **Physician** 2005 CORDEN 01 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) Examiner Mariner Health North Arundel Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F 5. Secial Security Number 216-34-4699 Year) **Funeral** Days Hours Yrs. January 14,1938 Maryland 67 Director Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "neturel", or Itams 23a or 28e-f show any injury or other traumatic event, Ita Michiel Examinat must be notified at once. 1 X Yes 2 ☐ No Director Maryland n/a Baltimore 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21223 United States 2696 Wilkens Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: Specify: White δ 3 Widowed 4 Divorced Year or Dates: 1956-62 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) mechanic maintenance 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ella Bock Charles Rent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30580 Waycroft Drive, Salisbury, Maryland 21804 Joyce E. Mulcare - sister 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/18/2005 | Crownsville, Maryland MD Veterans Cemetery 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Ligense 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ci Co day resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhiated events resulting in death) Last Due to (or as a consequence of): Examiner oh 081 and Due to (or as a consequence of): the attending physicien Physician/Medicai for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown ò 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ peq 3 Probably 4 Unknown 1 ☐ Yes 2/21No page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Be

Physician /Medical **Examiner**

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed certificate To the Hospitel or Attending Physician: this in by the funeral After after death.

Certification: To

Medical

State Registrar 1 Natural

2 ☐ Accident

3 Suicide

29a. Certifier

4 - Homicide

P.O. Box 68760.

Division of Vital Records.

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Hospital: 1 Inpatient 1 ☐ Yes 2 ☑ No 3 DOA 2 ER/Outpatient 27. Manner of Death 28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatur and title of certifier elival 04

0

5 Pending

investigation

6 Could not be determined

29c. License number 029873 29d. Date signed (Month, Day, Year) 01/17/2005

GLEN AURNIE,

Atknowing 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRAIN HWY, 7610

Physician

31. Date filed (Month, Day, Year) IAN 1 32. Registrer's Signature

DHMH 17 Rev 1/2001

within 24 hours aft To the Funaral Di completely filled in

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician Year 2005 6:25AM David Rothman anuale /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. Iderane renesis Caton Maron 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 X M 2 □ F unk Yrs. 70 Director 117-26-8752 June 4, 1934 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28a-f show 10d. Inside City Limits MD Baltimore 1X☐Yes 2☐No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? in than "natural", or items 23a or the Medical Examiner must be 3330 Wilkens Avenue 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: white 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk other than Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk .. Pages 1 and 2 should be fil tment of Health and Mental H tant: If Item 27 is marked otl jury or other traumatic even unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caton Manor Nursing Home 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State, Department o Important: If any injury or `4 □Donation 5 🗓Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 monlo 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Metastata /Medical **Examiner** Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 4 SUnknown 1 TYes 2 TNo page 2 should Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-40521

State Registrar 31. Date filed (Month, Day, Year)

DROCHANCY

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32. Registrar's Signature

30. Name and address of person with completed cause of death (Item 23a) (Type, Print) 3350 Wilkum Avinue

Conte

(Saltimory MD

Suite

Rothman

		1 - For State Registrar	State of Maryla	and / Dep	artment of F	lealth and	Mental Hyg	iene	5 01070
Physicia /Medic Examin	ai	1. Decedent's Name (First, Middle, Last	Rosen Fel	d tine	4b. City, Town, o	r Location of Deal	2. Date of Deat Month &	Day Yea 3 5 5 4c. County of De	Tro Aw
Funeral Director		5. Social Security Number 086-26-6892 1 Usual Residence of Decedent	7. Age (In y. ☐ M 2 🖫 F 69	rs. last birthday, Yrs.	1	If Under 24 Hrs Hours Min		^{year)} 1935 Ne	Birthplace (State or Foreign Country) W York
the Maryland 28e-f show	rector	10a. State 10b. County MD 10e. Street and Number	10c.	City, Town or La Balti				Object (Min	10d. Inside City Limits 1 ▼ Yes 2 □ No
urs urs	by Funeral Director	2434 W. Belveder 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	e Avenue 12. Was Decedent Ever in Amed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates:	U.S. 13.		1215 ispanic Origin? (S an, Mexican, Puer Specify:		USA 14. Race - Ar Black, Wt	nerican Indian,
AIAI ad within giene. er than "	Completed	15. Decedent's Ed (Specify only highest gradest gradest gradest) Elementary/Secondary (0-12) 12	ucation de <i>completed)</i> College (1-4or 5+) 5+	16a. Dece (Give life.	dent's Usual Occup kind of work done of DO NOT use retired teacher	ation during most of wo	rking	6b. Kind of Busines	•
should and Mer marke	To Be (17. Father's Name (First, Middle, Last) Harry Bram 19a. Informant's Name/Relationship (7)	ype, Print)	19b. Maili	ng Address (Street	Agusta	me (First, Middle, Market) Grossbe:	faiden Sumame)	
ss 1 and of Heal		JoAnn Rosenfeld/c 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 1 □ Word Specify Companion 3 □	laughter 20b Removal from Stage	1112 Place of Dispo	Nicodemu osition (Name of matory or other place	ıs Road I	Reisterst		21136
permit. Page Department of Importent: If any injury or once.		21. Sign trae of Funeral Service License Romand	Page Virect					Baltimore	Street
	sal Examiner	23a. Part1. Enter the disease or compensors of heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ne cause on each line.	equence of):		g, such as cardiac	c or respiratory arre	st,	Approximate Interval Between Onset and Death
The law requires that the death certificat ite has been signed by the attending phy age 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
	2	Part II. Other significant conditions co	ntributing to death but not re	esulting in the ur	nderlying cause give	n in Part I.			to the cause of death?
or Attending Physician: The law requires taffer death. Director: After this certificate has been signed in by the funeral director, page 2 should be	pajaidinos						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
or Attending Physician: The I after death. Director: After this certificate ha in by the funeral director, page	2	25. Was case referred to fieldical examiner? 1	lospital: 1 Inpatient 2[28a. Date of Injury (Month, Day Year)	☐ ER/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4 🗆 Nursing H	th (Check only one) ome 5 Residen 28d. Describe how	ce 6 Other (Spe	acify)
us after death. rei Director: After tiled in by the funeral		3 Suicide 6 Could n be determined	28e. Place of Injury - At building, etc. (Spec	city)			City or Town,		
To the Hospitel or At within 24 hours after of You have Linear Direct completely filled in by		one)	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	estigation, in my op-	inion, death occur	rred at the time, date	e and place, and du	e to the cause(s)
Mail William		29b. Signature and title of certifier 30. Name and address of person who or	ompleted cause of death (Ite	·	29c. License	615		Date signed (Mon.	th, Day, Year)
State Registrai		Andrew Backs 31. Date filed (Month, Ray, Year) 9 2		- Week	ter A	e Bu	et.more,	MD. 21	208

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F <i>rtificate of I</i>		Mental Hy	giene Reg. No.	
	Physic /Medi		Decedent's Name (First, Middle,		cott Reisig			2. Date of De Month Jan	Day 0 Oyes	3:15 am
7	Exami		4a. Facility Name (If not institution,			4b. City, Town, or			4c. County of D	eath Howard
	Funeral Director	Г		d County Genera 5. Sex 7. Ag 1 M 2 F	ge (In yrs. last birthday) 78 ^{Yrs.}	Months Days	If Under 24 Hrs Hours Min	8. Date of Bir (Month, Da	th 9.1	Birthplace (State or Foreign Country)
	and w		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	neation		→ May 4,	1926	MD .
	Maryli a-f sho	tor		Howard	ioc. Oity, Town of E		icott City			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28	Funeral Director	10e. Street and Number	TOTTUTU	-1-	10f. Zip Code	oct Oity		10g. Citizen of What	Country?
	ns 23e	eral	3209 Hearthstone Ro	12. Was Decedent	Ever in U.S. 13	Was Decedent of H	21042	Specify Ves or No		J.S.A.
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumatic event, the Medical Examinat must be notified at 000.8.	by Fun	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?	No	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	to Rican, etc.)	Black, W	
5-0	72 ho netur	eted	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of wo	rkin a	16b. Kind of Busine	ss/Industry
21215-0036	I within piene. r then "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5	5+) life.		n specialist		Ele	ectronics
	be filed tal Hygi d other	BeC	17. Father's Name (First, Middle, La	ist)		***************************************	<u> </u>	me (First, Middle,	Maiden Sumame)	
Maryland	2 should be filed withir and Mental Hygiene. is marked other then eumatic event, the M.	٦,	William 19a. Informant's Name/Relationshi	Gilmore Scott	105 14511	111			la Matilda Weig	,
	and 2 s salth an n 27 is er treus		Ms Brenda Wolf		_				er, City or Town, State Maryland 21042	
ore,	Pages 1 and 2 nent of Health, int: If item 27 i		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Removal from State	20b. Place of Dispo		!	Date	20c. Location - City	
Baltimore,	permit. Pag Department Importent: I any injury o		`4 ☐ Donā)ion 5 ☐ Other (Spe 21. Signature of Funeral Service Li	ocify)	Bayy	riew Cremator 2. Name and Addres	V	/13/2005	Baltir	more, MD
Ba	permit. Departr Importe any inju		Marchell.	111/		011-5		e, P.A.	. 011	
			23a. Part1. Enter the disease, or conhock, or heart failure. List on	omplications that ceused by one cause on each li	the death. Do not ent	er the mode of dying	g, such as cardia	PIKE EIIICOT or respiratory ar	t City, MD 2104 rest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_a Cere	bral F	nfarct				Onset and Death 3 Octy5
н	Examiner		Sequentially list conditions	, Gas	a consequence of):	strived	heed	Ding		2 weeks
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
oʻ	ficate be executed physician and is the burial-transit		that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					years
68760,	cate be physici the bu	edical		d						
Box	ath certi	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Ne	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	lelivery Day Year
P.0	that the de led by the detached		9 ☐ Unknown* Part II. Other significent condition		ut not resulting in the u	nderlying cause give	n in Part I	23e. Did to	bacco use contribute	to the cause of death?
rds	w requires that been signed should be de	ed by	Atrial Fi	ballation				1 □ Y	1/	Probably 4 □Unknown
Records,	e law re has bee	Completed	Hyperten:	5100				24a. Was a		autopsy findings available ocompletion of cause of
Vital F		e Cor	OF Was assessed to medical					perfor 1 ☐ Yes	med? death? 2 No 1 □ Ye	es 2 No
Ϋ́	Physician: this certifica al director,	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} 2 \text{YNO} \)	Hospital:	nt 2 ER/Outpatien	t 3 DOA Othe	_	th (Check only or ome 5 ☐ Resid	ne) ence 6 ⊡Other (Sp	necify)
o uc	ding Ph h. After th funeral		27. Manner of Death 1 SNatural 5 □ Pending	28a. Dale of Injur (Month, Day	y 28b. Time of	28c. Injury Work	at ?		ow injury occurred	
Division of	ten feat for: the	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be One Bleen of Init	ury - At home, farm, stre		es 2 □No	28f. Location (S City or Tow	itreet and Number or F n. State)	Rural Route Number,
	To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier Certifying	Physicien: To the best of	of my knowledge, death	occurred at the time	e, date and place	and due to the a		as stated.
RP	the Ho hin 24 the Fu npletel	Medical	one)	aminer: On the basis of and manner sta	examination and/or inv	estigation, in my op	inion, death occu	rred at the time, d	late and place, and du	ue to the cause(s)
	7 × 5 0	<	29b. Signature and title of contition	\sim	M	29c. License	number 5 8 7 4 -		29d. Date signed (Mor	nth, Day, Year)
			30. Name and address of person wh	o completed cause of de	eath (Item 23a) (Type, I				January	12,2005
			Randai Riese			larke Dr	Suit	e 200	Columb	ia 2104.4
	Sta Registr		31. Date filed (Month, Day, Year)	32. Hegistra	s Signature	House &				

			1 - For Stete Registrar	State of Ma		partment of Healertificate of De			11113	01072
			Decedent's Name (First, Midd	fle, Last)				Reg. Date of Death	NO.	3. Time of Death
	Physici		Geneva R.	RANDALL				Month JAN	Day Year	11 0 0 11
	/Medi Examir		4a. Facility Name (If not institution			4b. City, Town, or Lo	cation of Death	7// 1	4c. County of Deatl	1
1			How AILI) e	WIND CEN	DIAL NE	5/1946	ULUMBI	44	HOWA	
	Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthda	y) If Under 1 Year If	Under 24 Hrs. 8	Date of Birth		nplace (State or Foreign untry)
	Director		578-12-7510	1□M 200 F	86 Yrs.	Months Days F	Hours Min.	(Month, Day, Ye	1	
	P.		Usual Residence of Decedent				Se	eptember 11	1, 1918	Michigan
	arylar show	_	10a. State 10b. Count	у	10c. City, Town or	Location				10d. Inside City Limits
	8a-f	cto	Maryland	Howard		Col	lumbia			1 ☐ Yes 2 💢 No
	ith th	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	72 hours after death with the Maryland "natural", or Itams 23a or 28a-1 show died Exacility frougher refolitied at		10714 Hunting La	ne			21044		U.:	S.A.
	er de	Funerai	11. Marital Status	12. Was Decedent Armed Forces? rried 1 Tyes 2 X	Ever in U.S.	Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Specif Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Amer Black, White	
36	s afte	by Fi	1 Never Married 2 Ma	II TOS, GIVE	40	- +1	Specify:		Specify:	
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12	filed within Hygiene. thar than int, It e Me	E C	Elementary/Secondary (0-12)	College (1-4or 5	+)	,	/ Translat		Gove	ernment
9	be filed Ital Hygi d othar evant, I		17. Father's Name (First, Middle	. Last)			/_Typist I. Mother's Name (F	First Middle Mai	den Sumame)	
Maryland		To Be		Deed Hell			,			
<u></u>	d 2 should by th and Ments 7 Is marked traumatic en	Ĕ	19a. Informant's Name/Relation	Doc I. Hull ship (Type, Print)	19b. Ma	ailing Address (Street and	Number or Rural B		Powell	in Code)
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ē,	- ĭ a =	1 3	Mr. Alva Rang 20a. Megthod of Disposition	dall Husba	20b. Place of Dis	10714 Hunting L sposition (Name of	Larie Columbi		21044 Location - City or 1	Town, State
00	0		1 Burial 2 Cremation 4 Donation 5 Other		cemetery, c	rematory or other place)	0444			
Baltimore,			21. Sign dura of Funeral Salvice		Ola For	Lincoln Cemeter 22. Name and Address of	V	3/2005	Brentwood	d, Maryland
Ba	permit. Departr Importa any inju		Mallingalita	aliante in	000	01 1 5		ЭΔ		
			23a. Part1. Enter the disease of shock, or heart failure. Lis	r complications that caused	the death. Do not a	3871 Old	Columbia Pil	ke Ellicott C	ity, MD 21043	Approximate
			shock, or heart failure. Lis Immediate Cause (Final	t only one cause on each lin	10.			sophatory arrest,		Interval Between Onset and Death
	Pnysician / /Medical		disease or condition resulting in death)		Internici	blocd	C 55			Glacy S
	Examiner			Due to (or as	a consequence of):	C . L	. 1.	7 W. L.		-i .
		-	Sequentially list conditions,	b. Due to (or as	a consequence of):	Grastro 11	n 145 11276	1 13 11	Est	days
	ted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<	C ~ ~ 1 - / 3	10				dans
	xecu al-tra	xar	that initiated events resulting in death) Last	Due to (or as	a consequence of):	7.)				viney)
8760,	cate be executed physician and the burial-transit	dical E								
68	ficate phy s the	dic		d						
Вох	eath certific attending p for use as	W/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of deliv	1901
m	atter d for I	ciar	in the past 12 months?	1☐Live birth 4☐Pregnant at		3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
P.O.	that the de ed by the a detached t	ysi	9 Unknown	9□ Unknown						
σ	res that igned b be deta	y Pł	Part II. Dther significant condit	ions contributing to death bu	ut not resulting in the	underlying cause given in	n Part I.	23e. Did tobacc	co use contribute to	the cause of death?
200	ires sign	Ω	*						0 CM	
~	2 - 2	Ö	1 Vimo	K21 66				1 🗌 Yes	2 No 3 Pro	bably 4 Unknown
COL	w require	ieted		Kal W						
Recor	he taw requ e has been ige 2 should	ompieted	1 Pus	Ki i ii				1 Tes 24a. Was an autopsy performed	24b. Were autoprior to co	bably 4 Unknown opsy findings available impletion of cause of
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Univin 17 Rev 1/2001

State Registrar

Medical

THEO DONE MIKE 31. Date filed (Month, Day, Year) JAN 19

29b. Signature and title of certifier

29a. Certifier

40) 30. Name and address of person who completed cause death (Item 23a) (Type, Print)

29c. License number O.C.M.E 29d. Date signed (Month, Day, Year)

13, 2005

111 PENN STREET, BALTIMORE, MARYLAND 21201

and manner stated.

			For State Registrar		State	of Maryl	and / Dep	artmen				lental		ene	05	01071
	20		Decedent's Name (First, M.	liddle, La	st)	,						2. Date o		g. 1402 O	00	3. Time of Death
	Physici		Addie	Mar	do (Sheele						Jan.		Day 2005	Year	5:00 P ^M
	/Medic Examir		4a. Facility Name (If not instit				4	4b. City,	Town, or	Location	of Death	Jan	1.0	4c. County	of Death	J:00 F
1	LAdiiii	ici	3426 A 01d Le	17e1	Road	,				De Gr					rfor	1
	Funeral		5. Social Security Number	6. S	өх	7. Age (In	yrs. last birthday) If Under	1 Year	If Under	24 Hrs.	8. Date o	f Birth		9. Birth	place (State or Foreign
	Director		219-10-9909	1	☐M 2\\ F		84 Yrs.	Months	Days	Hours	Min.	June	24,	1920	Mar	vland
	p.		Usual Residence of Deceden													
	show	_	10a. State 10b. Con	-		100	. City, Town or L	ocation							1	10d. Inside City Limits
	Be-f	cto		larfo	rd		Havre	De Gra	ace				-,			1 ☐ Yes 2 No
	or 2	Director	10e. Street and Number					10f. Zip					10	g. Citizen of \	What Cou	ntry?
	ath v	rai	3426 A Old Le	vel					210					US.		
	er de Items	Funerai	11. Marital Status	4 4 to -d	12. Was Dec	orces?	in U.S. 13.	Was Deced If Yes, spec	lent of Hi cify Cuba	spanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes o Rican, etc.	r No-		e - Ameri ck, White,	can Indian, etc.
36	rs aft	by F	1 ☐ Never Married 2 ☐ I		If Yes, Gi	2 X No ive Pates:		1 ☐ Yes	2 X No	Specify:	:			Specify	v: Whi	te
Ö	within 72 hours after death with the Maryland ene. than 'natural', or items 23a or 28e-f show ha Madical Examinatin and be mullihed at	ed	15. Dece	dent's Ed	ducation		16a. Dece	dent's Usua	al Occupa	ation			1 10	6b. Kind of B	usiness/In	dustry
215	n n n	pie	(Specify only hi		de completed) College ((Give	kind of wor DO NOT us	rk done d se retired	luring mos)	t of work	ing				,
217	d with giene er the	Completed	6	۷)	N/A		1	Homema	aker						Own H	Iome
p	be filed tal Hygi d other event,	Be C	17. Father's Name (First, Mid	dle, Last)						18. Mothe	er's Nami	e (First, Mi	ddle, Ma	aiden Suman		
/lai	should be tind Mental I	70	Robert Baubl	itz						Agne	s Ti	1man				
Maryland 21215-0036	2 should be filed withir and Mental Hygiene. is marked other than eumatic event, the Ma		19a. Informant's Name/Relat	ionship (Турө, Print)		19b. Mail	ing Address	(Street a	and Numbe	er or Run	al Route N	ımber, (City or Town,	State, Zip	Code)
	rt.		Agnes Miller/	Daug	hter		3420	5 A 01	d Le	evel	Road	Hav	re I	e Gra	ce, M	D 21078
ore	es 1 au of Hea fitem r othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremate	ion 3 🗆	Removal from	State D	b. Place of Disp cemetery, cre oplar Gr	osition (Nan	ne of ther place	9)	Jan.	Date 18.	20	c. Location	City or To	own, State
Ē	Pages ment of I ent: If ite ury or o		'4 □Donation 5 □Othe			Me	opiar Gr eth. Chu	rch C	nite em.	a	200		P	hoenix	, MD	
Baltimore,	permit. Pages Department of Importent: If i any injury or once.		21. Signature of Funeral Sen	Ce Dicer	1500		2	2. Name an	d Addres	s of Facili	ty 1 II	£				T
_	90 = 90	41 1	1///	\$	Michae	21 J.	Flagle	10 W.	Pac	lonia	Roa	d Ti	moni	Laney Lum, M	210 210	y Inc.
			23a. Part1. Enter the disease shock, or heart failure.	or com List only	plications that	caused the deach line.	leath. Do not en	ter the mod	e of dying	g, such as	cardiac (or respirato	ry arres	t,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		. (DROP	NARY	Ap	7 EK	24	DI	SEA:	SE	-		Onset and Death
	/Medical Examiner		resulting in death)		Due to		sequence of):									309,-
ш	LXammer	_	Sequentially list conditions,		b		ERTE	STION	2							
	ed isit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	Due to	~	sequence of):				T-					
	be executed sician and burial-transit	xan	that initiated events resulting in death) Last		c. Due to		ASE 7 E		141)E _				_	-	
8760,	death certificate be executed e attending physician and od tor use as the burial-transit	dicai E														
687	ficate I physics the t	edic			_ 0											
Вох	leath certific attending p	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, ou									23d. Da	te of delive	erv
m	death e atte	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No		4☐Preg	birth 2□f nant at time		□Ectopic pro □ Other (sp					_	Mo		Day Year
0	at the de by the stached	hys	9 Unknown		9□ Unkn	nown									.,	
S, P	requires that the reen signed by th hould be detache	by P	Part II. Other significant con			leath but not	resulting in the u	inderlying ca	ause give	n in Part I		23e. [oid toba	cco use cont	ribute to th	ne cause of death?
rd	w require been sig should b		DEPR	ESS	2101							١	Yes	2 🗆 No	3☐ Prob	ably 4 Unknown
000	as bee	plet	EMP	HY!	SEMA								Vas an	24b. \	Vere auto	psy findings available
Vital Record	9 4 9	Completed											utopsy erforme	d?	death?	πpletion of cause of 2□ No
ta	ien: Th rtificate ctor, pag	BeC	25. Was case referred to me	dical	411.5					26. Place	of Death	(Check of		110		22.50
of V	Physicien: this certific ral director,	2	examiner?		Hospital: 1 🗆	Inpatient :	2 ER/Outpatie	nt 3 🗆 DO	A Othe	or: 4 □ Nu	rsing Ho	me a 🗆 f	esiden	ce 6 □Oth	er (Specif	y)
	g jet		27. Manner of Death Natural 5 ☐ Pe	ndina	28a. Date (Mon	of Injury oth, Day Yea	28b. Time o	of 2	8c. Injury Work	at ?				injury occurr		
Sio	Attending it death. ector: Atterby the fune	atic	2 Accident inv	estigation				M		/es 2□	No					
Division	al or Attendir atter death. I Director: At d in by the fur	Certification:		uld not be termined	280. Place	e of Injury - A	At home, farm, st ecify)	reet, factory	, office				n (Stre Town,		er or Rura	l Route Number,
	itel curs at rel D			4												
	To the Hospitel of within 24 hours at To the Funerel D completely filled it	edical	29a. Certifier 12 Cert (Check only one)	ifying Ph ical Exen	niner: On the b	pasis of exam	knowledge, deat nination and/or in	th occurred a vestigation,	at the tim in my op	e, date an sinion, dea	id place, i th occurr	and due to ed at the ti	the cau ne, date	se(s) and ma e and place, a	nner as st and due to	ated. the cause(s)
	ithin 2 o the	Mec	29b. Signature and title of cer	rtifier	↑	ner stated.		29c	. License	number			290	Date signed	(Month.	Dav. Year)
	+ 3 F 8		Para	4 - 1	100	# 1.	1.0		_	080			N	12/2	205	
6	1		30. Name and address of per	son who	completed cau	se of death /	Item 23a) (Type		41							
1	111		Dr. Archana	Sood	. M.D.	120	8 Church		Ros	nd #	201	Rol A	ir	MD 214	114	
	Sta	te	31. Date filed (Month, Day, Y	ear)	9 2005	Registrar's Si	ignature &	Spe	NO.	-u /		DCT H	4.4.9	.m	/ .	
10%	Registr	ar	JA	N 1	9 2005	DERE	fifteen Shed"	San	St. st.							

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of ertificate of		Mental Hy	giene		01075
	Physic	ian	Decedent's Name (First, Middle, La	•				2. Date of D Month			3. Time of Death
	/Medi	cal	Catherine Spina 4a. Facility Name (If not institution, gir			1		Jan.	17	2005	11:25 A M
	Exami	ner	Stella Maris	e street and number)			or Location of De Onium	ath		County of Death	
	Funeral		Social Security Number 6.	Sex 7. Age	(In yrs. last birthday	If Under 1 Year	If Under 24 H				
	Director			1□M 2 X F	97 Yrs.	Months Days	Hours Mi	July 2			place (State or Foreign ntry)
	and]	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation					10d lasids Ois 11 in
	the Marylar 28a-f show	to	MD Baltim	ore	Phoenix						10d. Inside City Limits 1 ☐ Yes 2 🙀 No
	or 28a	irec	10e. Street and Number	or c	1 11001112	10f. Zip Code			10g. Citi	zen of What Cour	
	death with the Maryland ms 23a or 28a-f show f must be notified at	alD	3 Thorndyke G	arth		21	131			USA	•
	s after death with the Maryla , or Items 23a or 28a-f show	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		Was Decedent of If Yes, specify Cub	Hispanic Origin?	(Specify Yes or Norto Rican, etc.)	0-	14. Race - Americ Black, White,	
36	irs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2√N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 🛣 No					hite
2-0	72 hours after "natural", or Ite	ted	15. Decedent's E	ducation		dent's Usual Occu			16b. Kir	nd of Business/In-	dustry
21	within 7	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5-	life	kind of work done DO NOT use retire	during most of w ad)	orking			,
2	filed with Hygiene. ther that	ဝိ	17. Father's Name (First, Middle, Last	n/a	Hoi	memaker				n Home	
and	should be filed within 72 h nd Mental Hygiene. marked other than "natu imatic event, the Wedical	To Be	Carmelo Manfre	,				_{ame (First, Middle} .isabetta			
Maryland 21215-0036	shoul ind Mi i mari umati	F	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street					(Code)
	es 1 and 2 should be fi of Health and Mental F fitem 27 Is marked ot r other traumatic ever		Carmela Thame	er/daughtei	r 3 TI	norndyke	Garth,	Phoenix	, ME	21131	0000)
altimore,	of He of He If item or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	ice)	Date	20c. Loc	cation - City or To	wn, State
ţi	t. Pag tment tant: ijury c		'4 Donation 5 Other (Special			deemer (1/05	Balt	timore, I	MD
Bal	permit. Pages 1 Department of H Important: If ite any injury or otl once.		Bryan W. Cla	Elikat	1	0 W. Pac	Funeral Ionia Rd	. Timor	าเมา	ney Val	ley, Inc.
	Physician /Medical Examiner		23a. Part1 Enter the disease, or comshock, or heart lailure. List only Immediate Cause (Fhal disease dr condition resulting in death)	a	consequence of):	1		ac or respiratory a		~ °	Approximate Interval Between Onset and Death
	ecuted and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):						
8760,	cate be executed physician and the burial transit	dical E		d	consequence of):						
P.O. Box 6	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ 46 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy	у		2:	3d. Date of delive Month	ry Day Year
Is, P	ires that signed to d be det	by P	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco us	se contribute to th	e cause of death?
Records,	w requir been si should	Completed by	Czajśiors	seuliv	al1550 52			10	Yes 2□	No 3☐ Proba	abiy 4 Minknown
3ec	ne law has t ge 2 s	du .						24a. Was autor	osy	prior to con	osy findings available on pletion of cause of
			05.11					1 Tes	rmed?	death?	2□ No
Vital	Physician: this certifica al director, j	0	25. Was case referred to medical examiner? 1 Yes 2	Hospital:	2 ER/Outpatien	t all post Oth		ath (Check only c			
		H	27. Manner of Death	28a. Date of Injury (Month, Day		1 3 DOM	Name and I	Home 5 Resid)
Sior	tendin leath. tor: Aff the fur	atlo	1 Accident 5 Pending investigation	r I	Year) Injury		k? Yes 2 □No				
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral to the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur building, etc.	y · At home, farm, stre (Specify)	eet, factory, office		28f. Location (S City or Tox	Street and vn, State)	Number or Rural	Route Number,
	e Hosp 24 hou e Fune letely fil	edical	29a. Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of niner: On the basis of e and manner state	xamination and/or inv	occurred at the ting restigation, in my o	ne, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) a date and p	and manner as sta place, and due to	ited. the cause(s)
	To the comp		29b. Signature and the of certifie	ad.	M	29c. Licens	e number	i i		signed (Month, D	
do	110		30. Name and address of person who e		th (Item 23a) (Type, I		D TIMON	TUM, MD	21002	2	
	Stat	0	31. Date filed (Month, Day, Year)		1			LUM, MD		•	
	Registra		JAN 1	9 2005	s Signature	July Robert					

CATHERINE SPINA JANUARY 17, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year January 15, THEODOROS THEODORE MICHAEL SAMARAS 2005 12:15 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore County COLLEGE MANOR Lutherville If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 1₹M 2□F 81 Greece <u> 219-36-1328</u> Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Lutherville Maryland Baltimore County 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21093 USA 135 Warwick Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 😾 No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plant Operator Asphalt Comapny 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Michael Samaras Athena Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rep) 613 Strandhill Court, 7 Phyllis E. Musgrove (Pers. Timonium, Maryland Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Demetris Gk Orth: 1/20/2005 | Parkville, Maryland 21. Signature W Fungay Service Lensed

Martin D. Lawson 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore Maryland 21212 enter the mode of dying, such as cardiac or respiratory areat, 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Meta Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

δ

Be

Funeral

Director

7 is markad othar than "natural", or items 23a or 28a-f show traumatic event, I'm Madical Examinate trast be netified at

permit. Pages 1 and 2 should be filed within 72 hours atter death v Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23a amy injury or other traumatic event, If a Madical Examinent once.

with the Maryland

signed by the attending physician and d be detached for use as the burial-transit Physiclan/Medical Completed by After !

P.O. Certification: al or Attend after death Diractor: To the Hospital o within 24 hours aft To the Funaral Di

23b. Was decedent pregnant in the past 12 months? I ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. mamia

1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide

29b. Signature and title of certifier

29a, Certifier

25. Was case referred to medical examiner?

5 Pending 6 Could not be determined 4 Homicide

1 Inpatient 2 ER/Dutpatient 3 DOA investigation

28a. Date of Injury (Month, Day Year)

28b. Time of

eng

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

9 Unknown

4☐Pregnant at time of death

U, abetes

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 024732

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

60/1000

1 ☐ Yes 2 ☐ No

Year

Month

23e. Did tobacco use contribute to the cause of death?

autopsy performed? 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ma

28d. Describe how injury occurred

1 Yes

26. Place of Death (Check only one)

1 Yes 2 No 3 Probably 4 donknown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

E. Timothy Souweine, 31. Date filed (Month, Day, Year)

32. Registrar's Signature

M.D., 21 West Road, Towson, Maryland 21204

3 Ectopic pregnancy

5 Other (specify)

DHMH 17 Rev 1/200

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State Registrar

Donovan Sampson Jr. 05-0299 Please Type or Print in Black Inde/ibje ink. Ensure All Copies Are Legible. unpend item#23a, 27, perME, 6842, inde/ibje ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AKG 1 - For State Registrar Reg. No.2 0 0 5 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** January 12, 2005 D. 4:16 PM Donovan Sampson Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland General Hospital Baltimore 8. Date of Birth (Month, Day, 12 17 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Year) 04 9. Birtholace (State or Foreign **Funeral** 26 Country MD Months Hours 216-71-6271 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location Show 10d. Inside City Limits 7 is marked other than "natural", or Itams 23e or 28e-f shov traumatic avant, the Madical Expertmen must be notified at 1X Yes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? 21216 death v Funeral 3107 Artaban Place U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. hours after 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 P. Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natuany injury or other traumatic avant, I'm Madical 2002e. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Donovan Sampson Sr. Myesha Gwynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3107 Artaban Place, Baltimore, Md 21216 Myesha Gwynn-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Park 1/19/05 Arbutus, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Congenital heart disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit be exec Due to (or as a consequence of): P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ò in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No 24a. Was an has autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2XXER/Outpatient 3 ☐ DOA 1 X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. January 13, 2005 nus 30. Name and address of person who completed se of death (Item 23a) (Type, Print) THEWOME M. KE 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JAN 1 9 2005

ORIGINAL

			For	artment of Health and Mer		2005	01078
			Hegistrer 1. Decedent's Name (First, Middle, Last)		Date of Death	. NG. UUJ	3. Time of Death
	Physici		Steven Anthony Shawe	\	Month ANJAKA	Day Year	2118 M
T	/Medic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Maria	4c. County of Death	
1			Sinai Hoseima	BALTIMORE			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min.	Date of Birth Month, Day, Y	9. Birthpi 1934 UNK	lace (State or Foreign try)
	Director	}	208-26-9962 1⊠M 2□F /U Yrs.		SEP 29,	1934 UNK	
	yland 10W		10a. State 10b. County 10c. City, Town or L		-	10	0d. Inside City Limits
	a-fe	ctor	MD N/A Baltimore	e 			1X Yes 2 □ No
	within 72 hours after death with the Maryland ane. ttan "naturel", or Items 23a or 28a-f ehow the Marical Exempler must be mullied at	Funeral Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Coun	try?
	s 23a	rall	2203 Liberty Heights Avenue	21217		USA	and the state of
	ter dea Items Iner ov	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{ Never Married} \) 2 \(\text{ Married} \) 12 \(\text{ Ves z } \) 2 \(\text{ Mar} \)	Was Decedent of Hispanic Origin? (Specifi If Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - America Black, White, 6	
21215-0036	urs aff	by	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: whi	te
20-0	72 hor	ted		edent's Usual Occupation a kind of work done during most of working	16	ib. Kind of Business/Inc	dustry
21	be filed within 72 ho tal Hygiene. d other than "natu event, tre Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
2	iled Hygi ther nt, II		UNK 17. Father's Name (First, Middle, Last)	nk 18. Mother's Name (F	irst Middle Ma	unk	
Maryland		э Ве	unk	unk	wot, whate, wa	iddir Odiridirio)	
ary	2 shoul and Me is mark eumati	ို	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural R	Route Number, C	City or Town, State, Zip	Code)
	alth a		Mary Shawe - ex-wife 1575	Williams Avenue, Es	ssex, M	21221	
ore	000			matory or other place)		c. Location - City or To	
Ĕ	Pages ment of ent: If it		'4 □ Donation 5 □ Other (Specify) Chesapeake	Crematory Inc 01/19/0		eltsville,	MD
Baltimore,	permit. Page Department Importent: If any injury o		21. Signature of Funeral Service Licensee MO0986	AFA, Stephen D. Lohi 717 Green Pastures I	rmann, I Drive, 1	PA Towson, MD	21286
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	iter the mode of dying, such as cardiac or re	espiratory arrest	t,	Approximate Interval Between
E	Pnysician	7. II	Immediate Cause (Final disease or condition a. ANOVIC ENCENTAGE	PATHY			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	311			
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):				
	uted d ansit	Examin	cause. Enter Underlying Cause Disease of injury that initiated events c.			-	
oʻ	a exectan an an arial-tr	Еха	resulting in death) Last Due to (or as a consequence of):				
8760,	The law requires that the death certificate be executed that been signed by the attending physician and age 2 should be detached for use as the burial transit	dlcal	d				
9	eath certific attending p	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			20d Date of deliver	
Вох	atten for us	Physician/Me	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
o.	by the tached	Jysk	1 Yes 2 No 9 Unknown				
ري م	res that igned b	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to th	e cause of death?
rd	aquire en sig ould b	ed k	lung carlete		1 🗌 Yəs	2 No 3 Proba	ably 4 Sunknown
Records,	e law requ has been je 2 shoule	Completed	600		24a. Was an autopsy	24b. Were autop	osy findings available
		Con	CARDIONIZOPETHS		performe 1 Yes 2	d? death?	2 No
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (C	Check only one)		_
of	hys this al di	. To	1 ☐ Yes 2 ☑ No 1105pinal: 1 ☑ Inpatient 2 ☐ ER/Outpatie 27. Manpér of Death 28a. Date of Injury 28b. Time of	The second secon	5 Residence d. Describe how	ce 6 ☐Other (Specify injury occurred)	")
on	ding F th. After funer	tlon	1 X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	of 28c. Injury at 28c Work? M 1 ☐ Yes 2 ☐ No		,,	
Division	of or Attendii after death. I Director: A d in by the fu	Certification:	3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could not be determined building, etc. (Specify)	treet, factory, office 28f	Location (Stree City or Town, S	et and Number or Rural	l Route Number,
	tel or A	Cert	building, etc. (Specify)		ony or 7 omi, c		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal care on the basis of examination and/or in and manner stated.	th occurred at the time, date and place, and nvestigation, in my opinion, death occurred	d due to the caus at the time, date	se(s) and manner as sta a and place, and due to	ated. the cause(s)
	To the vithii To the comp	Me	29b. Signature and title of certifier	29c. License number	29d	l. Date signed (Month, L	Day, Year)
	\circ		> 70 L 22 mg	265-400	مل ا	Nuray 12,	2005
	,7		30. Name and address of person who completed cause of death (Item 23a) (Type			,	
	Sta	10	J. A. Yorto, Mb 2401 W. BEWE DOW WENTE 31. Date filed (Month, Day, Year) 32. Registrar's Signature	DANTIMORE, MO 21215			
;	Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 1 9 2005	Coole			

			For State Registrar	State of Mar	yland /		rtment of H			-	giene Reg. No.	41115	01079
			Decedent's Name (First, Middle, Las	t)	<u>.</u>					2. Date of De			3. Time of Death
	Physici /Medio		Michael C. Stro							JANUAR	24 /	4,2005	2:35 PM
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, or Lanhan		of Death	•		County of Death	
	Funeral		Doctors Communit 5. Social Security Number 6. Secu	7. Age (In yrs. last b	oirthday)	If Under 1 Year	If Unde	er 24 Hrs.	8. Date of Bir (Month, Da		9. Birth	place (State or Foreign
Ш	Director		215-48-5001	ĎM 2□F	58	Yrs.	Months Days	Hours	Min.	Jan 6,	1947		otry) 1and
	and w		Usual Residence of Decedent 10a. State 10b. County	1	IOc. City, To	wn or Lo	ation						10d. tnside City Limits
	Marylan H show	tor	MD Prince G	eorge's	Bowi	e							1 ☐ Yes 2 💢 No
	th the	Olrec	10e. Street and Number				10f. Zip Code					izen of What Cou	•
	s 23a	rai	4912 Rocky Spring		:- 11.0	10.11	20715					ed State	
920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "neturel", or Items 23a or 28e-f show aumatic event, the Medical Extribute Intelligation	by Funeral Director	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	er in U.S.	li li	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2X No	n, Mexica Specify	an, Puerto R	ny yes or No ican, etc.)		14. Race - Ameri Black, White, Specify: Whi	etc.
2	72 ho	eted	15. Decedent's Ed (Specify only highest grad		16	(Give I	ent's Usual Occupa	luring mo	st of working	9	16b. Ki	ind of Business/Ir	ndustry
12	within ane. Ihan *	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			il Manage		·		C1	othing	
<u>б</u>	illed Hygid other ent, I	Be Co	17. Father's Name (First, Middle, Last)			i.c.ca	r ranage		ner's Name ((First, Middle,	Maiden	Sumame)	
lar	should be tod Menta s marked umatic ev	To B	Cornelius Strotman	n				Ar	na Do	ris No	rton		
Maryland 21215-0036	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (7				g Address (Street a						o Code)
	1 and Healt tem 2		Jayne Strotman/ 1 20a. Method of Disposition		20b. Place	of Dispos	Rocky Spr		Da	te	-	cation - City or T	own, State
altimore,	Pages ent of nt: If I		1 ☐ Burial 2 XCremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		_		atory or other place e Cremato		Jan 19	9,	Bel	tsville,	MD.
Balti	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		21. Signature of Funeral Service Licen	SOO M	0G8G6	22 C	Name and Addres remation 717 Green	s of Facil	Funer	al Alte	erna alti	tives). 21286
	Physician /Medical		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		Tice	cho		g, such a	s cardiac or	respiratory ar			Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Exercises or injury	b. Due to (or as a c	consequence	e of):							
8760,	icate be executed physician and s the buriat-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c	consequence	e of):							
687	flicate p phys	edical		d									
.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal deal		Ectopic pregnancy Other (specify)				2	23d. Date of delive Month	ery Day Year
s, D	es that gned b	by P	Part II. Other significant conditions co	ontributing to death but	not resulting	in the un	derlying cause give	n in Part	I.				he cause of death?
ord	w require been si should t	eted	- thy fee cal ce	WG						1 🗆 Y	es 2	□No 3 □ Prot	bably 4 🗷 Unknown
al Records,		Completed										24b. Were auto prior to co death? 1 \(\sum \text{Yes}	psy findings available mpletion of cause of
Vita	rsician: Th s certificate lirector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No	Hospital: 1 Nipatient	2 🗆 ER/O	Outpations	3□ DOA Othe	VC		Check only o		S □Other (Specif	iv)
J Of	ding Phys h. After this funeral di	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day)	28b	Time of Injury	28c. Injury Work	at		d. Describe h			97
Sior	Attendin death. ctor: Aft y the fur	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be				M 1 🗆 Y	/es 2 □					
Division of	al or Att	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	- At home, (Specify)	farm, stre	et, factory, office		28	If. Location (S City or Tow	Street and m, State)	d Number or Rura)	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C		vsician: To the best of iner: On the basis of example and manner state	xamination a								
	Total Within	W	29b. Signature and title of certifier	558/2			29c. License D46	09	3		111	signed (Month, 5/05	
	M	l l	30. Name and address of person who co Radman Mustagh	ompleted cause of deal	th (Item 23a Hanu)	(Type, F	Print) Pus Kway	,6	runb	ult, or	00 .	20770	
:	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	1							
	Registr	21 2	JAN 1 9 201	15 Mague	J.	DO	Well						

ORIGINAL

			For State Registrar	State	of Maryla	and / Dep <i>Ce</i>	artment rtificate			and M	_	giene Reg. No.	71115	01	080
	Dhusisi		1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	ath Day	/ Year	3. Time	of Death
	Physici /Medic		LOTTIE MAR								Januar	y 15	2005		:48a ^M
	Examin	er	4a. Facility Name (If not institution,	give street and n	ımber)		4b. City, T	own, or	Location of	of Death		4c.	County of Deat	h	
	F		12302 EASTERN A	AVENUE 6. Sex	7. Age (In vi	rs. last birthday		ASE Year	If Under 2	24 Hrs.	8. Date of Bir	th	BALTIMO 9. Birt		or Foreign
	Funeral Director		213-32-6889	1□ M 2 000	, · · · · · · · · · · · · ·	94 Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da October			hplace (State untry) IARYLAN	
	pu ,		Usual Residence of Decedent		10-	City, Town or L								,	
	shov	or.	10a. State 10b. County		106.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,								10d. Inside (s 2 XNo
	hours after death with the Maryland turel', or Items 23e or 28e-f show at Examiner must be notified at	Director	MARYLAND BALT: 10e. Street and Number	IMORE		CHA	ASE 10f. Zip (Code				10a. Citi	zen of What Co	untry?	
	3e or		12302 EASTERN	ATTMATTA				1220	1				S.A.		
	death	Funerai	11. Marital Status		cedent Ever in	U.S. 13.				gin? (Spe	ecify Yes or No Rican, etc.)		14. Race - Ame Black, White		
8	or Ite		1 Never Married 2 Marrie	d 1 ☐ Yes If Yes, G	2 🔀 No ive		1 Yes 2		Specify:	, , , ,	riioari, oto.,	;	Specify: BLA		
2-003p		ed by	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's	Year or	Dates:	16a Dece	dent's Usual	Occupa	ition			16h Ki	nd of Business/		
Ċ	within 72 ho ene. than "natu	piet	(Specify only highest Elementary/Secondary (0-12)	grade completed	(1-4or 5+)	(Give	kind of work DO NOT use	done d retired,	uring most	t of worki	ing	TOD. IXI	114 01 043111633	moustry	
7	d will	Completed	6th grade	College	(1-401 5+)	HOUS	SEWIFE					N	I/A		
ana	be file tal Hyg d othe event,	Be	17. Father's Name (First, Middle, La	ast)					18. Mothe	r's Name	e (First, Middle,	Maiden	Sumame)		
<u> </u>		٩	RICHARD BROWN	(T. D.)							MYLES		- 0		
20	nd 2 sh lith and 27 Is n r traun		19a. Informant's Name/Relationshi									•	r Town, State, 2	ip Code)	
ē,	Hee Hee the		Viola Myers/Dat 20a. Method of Disposition	ugnter	20b	. Place of Dispo	osition (Name	e of	- 1	- 000	ase, Md Date		cation - City or	Town, State	
EIII	8° = 5		12 Surial 2 □ Cremation 3 `4 □ Donation 5 □ Other (Spe			cemetery, cre HOLLY H			1	01-2	0-05	MIDE	LE RIVE	R. MAF	RYLAND
ספונו	permit. Pa Departmen Important: any injury.		21. Signature of Juneral Service Li		11	W		CE	BROWN	COM	MUNITY		CRAL HOM		
	THE STATE OF THE S		23a. Par 1 Inter the disease, or c shock, or heart failure. List or	omplications that	caused the de		206 W terthe mode		-			rrest,		Approxima Interval Be	ate
	Physician		Immediate Cause (Final disease or condition	my one cause on	14	1 CEN	TET	127	No					Onset and	Death
	/Medical		resulting in death)	aDue to	(or as a cons	equence of:						. (20	_	25_1170	
	Examiner	_	Sequentially list conditions,	b	(cras a cons	(E)TV,	16	+7	EM	G	(-DIL	.v /u.	1)EME	24	n.a
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dusto	(ci as a coiis	AA(15	m.	4	OF	- C1	truma	- D	17500	54	RS
ŕ	be executed ician and burial-transit	Exar	that initiated events resulting in death) Last	c Due to	(or as a cons								- 0.0		
00/	ate be executed hysician and the burial-transit	ical		d											
9	artifica ing ph e as th		IF FEMALE:												
500	ath ce	Physician/Med	23b. Was decedent pregnant in the past 12 months?		birth 2 🗆 F	etal death 3	Ectopic pre					2	23d. Date of deli Month	very Day	Year
	he de	ysic	1 ☐ Yes P☐No 9 ☐ Unknown	4∐ Preg 9□ Unkr	nant at time o lown	rdeath 5L	Other (spe	спу)							
<u>,</u>	w requires that the death certifica been signed by the attending pt should be detached for use as t	þ	Part II. Other significant condition	_	leath but not r	-	inderlying ca	use give	n in Part I.		23e. Did to		se contribute to	the cause of	
colds,	v requ	Completed		,			_				24a. Was		24b. Were au		
נו ב	he lav e has ige 2	дшо									autop perfo	sy rmed?	prior to death?	ompletion of	cause of
2	an: T tificate or, pa	e Co	25. Was case referred to medical					-	26 Place	of Death	1 Yes	No No	1 L Yes	2 No	
>	ysick is cer direct	To B	examiner?	Hospital: 1	Inpatient 2	☐ ER/Outpatier	nt 3 DOA	Othe					Other (Spec	eify)	
5	ng Ph fter th meral		27. Manner of Death Natural 5 Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury	f 28	c. Injury Work	at ?		28d. Describe h				
2	*Attending Physicien: The lav ar death, ractor: After this certificate has by the funeral director, page 2	cati	2 Accident investiga 3 Suicide 6 Could no	t he			М		'es 2□N		204 1 1			10	_
5	or At after of Dirac in by	ertification;	4 Homicide determin	Ad 280. Flac	e of Injury - At ling, etc. (Spe	home, farm, str city)	reet, factory,	office			City or Tox		d Number or Ru	rai Houte Nui	nber,
	To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 burus atter death. within 24 burus atter death. completely filled in by the funeral director, page 2 should be detached for use as the	Medicai C	29a. Certifier Check only one)	Physician: To th	asis of exami	nowledge, deat	h occurred a vestigation, i	t the tim	e, date and inion, deat	d place, a	and due to the e	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	o the o the omple	Mec	29b. Signature and title of certifier	and mar	ner stated.	\wedge			number				e signed (Month		
	1 0		botail 1	Rusta	J (Jan w	1)_U	802	5		1-	17-2	2005	
	118		30. Name and address of person with Soltan L M.		s of death (It		Print)		YES!	40	ANE	B	ATO, N	1051	237
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Sig				0 -7	,		/	/ /		
	Registr	4	JAN 1 9 2	005	allers .	Nº An	sell)								

Juur	te	For 1 - State Registrar	State of Maryla		tificate of			g. No O	F 01001
Physici		1. Decedent's Name (First, Middle,			-	J	2. Date of Death		9:10P. M
/Medic Examir		DIONNE R. 4a. Facility Name (If not institution, game) 200 BLK. REEDBIRD	SAULTER give street and number) AVE		4b. City, Town, o	r Location of Death		4c. County of	
Funeral Director		213-92-0134	1□M 2IXE	. last birthday) 26 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, SEPT 14		Birthplace (State or Foreign Country) MARYLAND
Department of Health and Mental Hygiene. Important: If item 27 ia marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at <u>once</u> .	JO.	Usual Residence of Decedent 10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 [X]No
a or 28a- be notifi	Director	10e. Street and Number	IMORE	OWIN	GS MILLS 10f. Zip Code		10	g. Citizen of Wh	
minermus	Funeral	9 STABLE COURT 11. Marital Status 1 🖾 Never Married 2 🗆 Married	12. Was Decedent Ever in I Armed Forces?	'	21117 Was Decedent of H f Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		American Indian, White, etc.
dical Exa	eted by	3 Widowed 4 Divorced 15. Decedent's (Specify only highest	Year or Dates:	16a, Deced	lent's Usual Occup		ng 1	6b. Kind of Busi	BLACK ness/Industry
nt, ina ma	Completed	Elementary/Secondary (0-12) 12th grade 17. Father's Name (First, Middle, La	College (1-4or 5+) Lyr		NG TECHN:	,			PARENTHOOD
ATIC OVER	To Be	JOHN D JORDAN	SR.			MARY SA	ULTER		
ler traum		John D. Jordan	Sr./Father	9 Sta	ble Cour	and Number or Rura t, Owings	Mills,		
		20a. Method of Disposition 12 □ Cremation 3 14 □ Donation 5 □ Other (Spe	(KI	NG MEMO	sition (Name of natory or other plac RIAL PARI	K 01-18			ity or Town, State E, MARYLAND
any in		21. Signatur S F Jal Mark	ensee DUUM	WI		ss of Facility BROWN COMN TH AVENUE	UNITY F	UNERAL E	HOME P.A.
sician edical		23a. Patu Firef the disease, or constant shock, or heart failure. List or immediate Cause (Final disease or condition resulting in death)	implications that caused the deally one cause on each line. a. Due to (or as a conse	Stal.		uttive u			Approximate Interval Between Onset and Death
iner	Examiner	Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Dua to for as a conse	quence of):					
	cai	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ▼ Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)	/		23d. Date of Month	
מס מס מסור	by	Part II. Other significant condition	s contributing to death but not re	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	V	ute to the cause of death?
	Completed						24a. Was an autopsy perform	ed? prid	re autopsy findings available for to completion of cause of th? Yes 2 □ No
to the Funerel Director: After this certificele has a completely filled in by the funeral director, page 2 s	To Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatien	t 3 DOA Oth	26. Place of Death er: 4 Nursing Hon	2 - 112000		(Specify) SCENE
completely filled in by the funeral director, page		27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	(10/0)	28b. Time of Injury	28c. Injur Wor 1 🗆	y at k? Yes 2 No	8d. Describe how Subjec		ned acut
ופת ווי בל	Certification;	3 ☐ Surcide 6 ☐ Could no 4 ☐ Homicide determin	building, etc. (Spec	nome farm, straits) Foun	eet, factory, office d in Park		Reedbir	dAve	or Rural Route Number, L 200 BIL Baltwaver/1
pletely fil	Medical	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best of my kn aminer: On the basis of examin and manner stated.	owledge, death ation and/or inv	occurred at the tin restigation, in my o	ne, date and place, a pinion, death occurre	nd due to the car d at the time, dat	use(s) and mann te and place, and	er as stated. d due to the cause(s)
Ē.	Σ	29b. Signature and title of certifier	0.0	1	29c. Licens				Month, Day, Year)
		arola	allan w	a	0.0	.M.E.	JA	NUARY 12	2,2005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 2. Date of Death Day Month Year TALLAGSEN

1 Decedent's Name (First, Middle, Last) **Physician** 2005 HTL 3 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner MANORCARE ROLLAND PARK Baltimore N/A If Under 24 Hrs. 5. Social Security Number 216–24–9856 If Under 1 Year 8. Date of Birth (Month, Day, Year) April 12,1929 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days Hours 1 □ M 2 ▼F 75 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "nature!" --- eny injury or other treumetic even. 10a. State 10b. County 10c. City, Town or Location MD N/A Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3838 Roland Avenue Apt. 302 21211 U.S.A. Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ №
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📆 🏋 o Specify: Specify: White þ If Yes, Give Year or Dates: ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fatory Worker Hedwin Corp. 9th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Martin Dinsmore Mary Rigler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Geraldine Gunnip (Niece) 4432 Newport Avenue Balto, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Memorial Park 1/17/5 Elkridge, MD 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home 3631 Falls Road Balto, MD 21211 Part 1. Erner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cade on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner led by the attending physician end deteched for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

þ Completed Be Certification: To

The law requires that the death certificate be executed been signed by the should be detech After this certificate has i or Attending Physicien: after death. Diractor: After this certifice Hospital

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

3 □ Suicide

29a. Certifier

Medical To the vithin 2

State Registrar

29b. Signature and title of certifier

MD

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number D 31464

28c. Injury at Work?

1□ Yes 2□ No

1 Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 1114105

28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an autopsy performed?

1 Tes

28d. Describe how injury occurred

Enlaw St Inte 300 Balt, m0 21201

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 1 No

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

XX Yes 2□ No

250

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

28a. Date of Injury (Month, Day Year)

HAP I Jan 1 821 N. 540A113

31. Date filed (Month, Day, Year) JAN 1 9 2005

5 Pending investigation

6 Could not be determined

32. Registrar's Signature Spark LAUNA

Amy Vidhyabhum Amend items 15,18,19a per fh g844 6-28-05 vt
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 283 per me G840 2-17-05 tas.

Amend Item 283 per me G840 Department of Health and Mental Hygiene 10 15 05-00227 MLO. 1- State Amend Item 1&Unpend Item 23a&Gartinestener Geral 2-3-05 tas Reg. No. 2. Date of Death 1-9-05 1. Decedent's Name (First, Middle, Last) Month **Physician** Amy Vidhyaphum Januar y /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore **Baltimore City** St Agnes Hospital If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 🔀 F 22 Director 215-08-0482 August 15, 1982 California Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit: ? Is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Director Ellicott City Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number U.S.A 21043 4202 VFW Lane deeth 1 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: within 72 hours efter 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry parmit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene important: if item 27 is marked other than "ns any injury or other traumatic event, it a Mucila page. Insurance Agency Elementary/Secondary (0-12) College (1-4or 5+) Administrator 18. Mother's Name (First, Middle, Maiden Syrname)
Parkchareonpisal
Suthida Vidhyaphum 17. Father's Name (First, Middle, Last) Be John Vid 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Suthida Vidhyaphum Mother 4202 VFW Lane Ellicott City, Maryland 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/14/2005 Baltimore, MD 4 □Donation 5 □ Other (Specify) Bayview Crematory 21. Signature of Frineral Service 22. Name and Address of Facility Menteller Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death In mediate Cause (Final disease or condition resulting in death) **Physician** a Myocarditis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year certificete has been signed by the atteiractor, page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1

Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No Hospital or Attending Physician: ours after death.

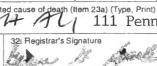
neral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home P XXYes 2 No 2X ER/Outpatient 3 □ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifies Medical

State Registrar

31. Date filed (Month, Day, Year 9 JAN

29b. Signature and title of certifier



29c. License number

111 Penn Street, Baltimore Maryland 21201

OCME

29d. Date signed (Month, Day, Year)

January 11, 2005

To the

			State of Maryland /								egible.		
			1 - State Registrar	Cer	tificate	e of L	Death			g. No:	005	0108	4
	Physici	an	1. Decedent's Name <i>(First, Middle, Last)</i> Howard D. Whittington						. Date of Deat Month	Day	Year	3. Time of Death	M
>	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)		4b. City,	Town, or	Location o		anuary	4c. C	200 county of Dea		
	L Xaiiiii		Union Memorial Hospital				timor				N/A		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last to 1.5 \$\frac{1}{3}\fra	birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. N	Date of Birth (Month, Pay, OV • 14,	Year)	G	thplace (State or Forei cuntry) t Virginia	ign
	υ		Usual Residence of Decedent								wes		
	Maryla f shov	ō	Maryland N/A	WII OI LO		Ltim	ore					10d. Inside City Limi XXYes 2□N	
	th the I	Funeral Director	10e. Street and Number		10f. Zip		<u>,</u>		10	g. Citize	en of What Co	-	
	s 23a c	ral	3122 Chestnut Avenue	40.1	1		2121					SA	
(0	r Itams	Fune	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ☑ Married 11. Was Decedent Ever in U.S.	i				in? (Specific , Puerto Ric	y Yes or No- can, etc.)	14	4. Race - Ame Black, Whit		
003	ural', o	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1□Yes 3							hite	
15-	in 72 h	piete	(Specify only highest grade completed)	(Give	lent's Usua kind of wor DO NOT us	k done d	luring most	of working		_	of Business enuit		
212	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "natural", or Itams 23e or 28e-f show event, the Medical Examiner must be nutilled at event, the Medical Examiner must be nutilled.	Completed	2		Fore	eman				& Ru	ıbber (Company	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or flams 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be nutitled at once.	Be	17. Father's Name (First, Middle, Last) James W. Whittington						First, Middle, M ret Eve		,	rman	
aryl	shoul and Me s mark	은	19a. Informant's Name/Relationship (Type, Print)				and Number	r or Rural R	Route Number,	City or	Town, State,	Zip Code)	
S,	1 and 2 Health sm 27 i						Avent	ue Ba			Marylaı ation - City or	nd 21211	
nor	ages ant of h ht: If ite y or of		Ceme	tery, cren ourg	Cemet	her place ery	1	/17/0				1, Maryland	d
Baltimore,	permit. F Departm Importsr any Injui		21. Signatur 7 Funeral Service Licenses	22 R1	. Name and	Addres	s of Facility	tz F	unoral	Home	Tnc		
<u>m</u>	80589		23a. Part 1. Enter the disease, or complications that caused the death. D	36	31 Fa	115	Road	Bal	uneral timore,	Mar	cyland	21211 Approximate	
	Priysician		shock, or heart failure. List only one dause on each line.			les:	g, such as c	Jardiac of It	ospiiatory and	31,		Onset and Death	
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence)	e of):	Shoc	STE						3 Days	
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,097	te be executed ysician and le burial-transit	ai Exa	resulting in death) Last Due to (or as a consequence	e of):									
687		edicai	d.										
Вох	death certifica e attending ph ed for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea	ith 3	Ectopic pre	gnancy				23	d. Date of de		
о. П	00	ysici	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 9 Unknown 9 Unknown		Other (spe						Month	Day Year	
s, P.	The law requires that the ate has been signed by the bage 2 should be detache	y Ph	Part II. Other significant conditions contributing to death but not resulting	g in the ur	nderlying ca	use give	n in Part I.		23e. Did tob	acco use	contribute to	the cause of death?	
ords	w require been sig should b								1 □ Ye	s 2 🗆	No 3□P	robably 4 Unknow	m
Vital Record	has be	Completed							24a. Was ar autopsy perform	,]	24b. Were at prior to death?	utopsy findings availab completion of cause of	le f
ta	ysician: The I is certificate ha director, page	O	25. Was case referred to medical				26. Place	of Death (C	1 ☐ Yes 2	No	1 🗆 Yes	2 No	
	Physician: this certificaral director, p	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/C			-	r: 4 □ Nur	sing Home	5 Reside	nce 6 (ecify)	
ono	ding P. h. After funera	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year)	. Time of Injury	M /	3c. Injury Work 1 □ 1	at ? (es 2.⊟N		d. Describe ho	w injury o	occurred		
Division of	r Atten er deal rector. by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory	office		28f	Location (Str City or Town		Number or R	ural Route Number,	
۵	pital or A			lee dooth		-4.45		1-1					_
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the bast of my knowled 2 Medical Exeminer: On the basts of examination and manner stated.	and/or inv	estigation,	in my op	e, date and inion, deat	n place, and h occurred	at the time, da	use(s) ai te and p	lace, and due	s stated. e to the cause(s)	
	Within To the comp	3	29b. Signature and title of certifier				number	11.6	29	d. Date	signed (Mont	th, Day, Year)	
)	10/		Danielle F. Grandumo, N 30. Name and address of person who completed cause of death (Item 23a	1.1)	A Print)	12	4389	46	J	anva	ry 14.	2005	
	IV'		Danielle F. Grandrimo M.D. 201 E. U.	niver	sita.	Bork	Wais	Balt	imore.	MD	2121	8	
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a Danielle F. Grandrimo M.D. 201 F. U. 31. Date filed (Month, Day, Year) 32. Refistrar's Signature	4. 1	gordin		0						
	ricgioti	ea a	Olive T o case										

				For State		Maryland /	Departn	nent of H	lealth and M	•	•	ore.		
				Registrar			Certific	cate of l	Death		eg. No.	15	01085	<u>.</u>
		Physici	an	Decedent's Name (First, Middle, L.	ast)					2. Date of Deat Month	Day	Year	3. Time of Death	
		/Medic Examir	cal .	Margaret Mar 4a. Facility Name (If not institution, g.	V		4b.	City, Town, or	Location of Death	January	15, 20 4c. County		6:35 A M	
				Gilchrist Hosp	ice			To	wson			Balt:	imore	
		Funeral			Sex	7. Age (In yrs. last b		Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth			lace (State or Foreign	1
	l.	Director		014-18-0580 Usual Residence of Decedent	1□M 2XF	85	Yrs.			Oct. 5,			nada	
		yland		10a. State 10b. County		10c. City, To	wn or Location	n				1	0d. Inside City Limits	
	2	death with the Maryland rms 23e or 28e-f show r must be notified at	Director	MD Balti	more		Timo	nium					1 ☐ Yes 2X No	
	3	or 26	Dire	10e. Street and Number			10	of, Zip Code		1	0g. Citizen of V	Vhat Cour	ntry?	
		ath w	rail	2119 Old Pine Ro					093		USA			
		er de Items	Funerai	11. Marital Status	12. Was Dece Armed For 1 Tes	dent Ever in U.S. rces?	13. Was I	Decedent of H , specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)		e - Americ k, White,	ean fndian, etc.	
	21215-0036	2 should be filed within 72 hours after death with the Marylan and Menhal Hygiene. and Menhal Hygiene. le marked other than "neturet", or litems 23e or 28e-f show eumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	If Yes, Giv Year or Da	е	1 🗆 Y	es 2∏X No	Specify:		Specify	Whi	ite	
	15-0	n 72 h	Completed	15. Decedent's (Specify only highest g	rade completed)		ia. Decedent's (Give kind life. DO N	Usual Occup of work done of OT use retired	during most of work	king	16b. Kind of Bu	siness/In	dustry	
	212	d with giene. er ther	omb	Elementary/Secondary (0-12)	College (1 N/			maker	,		Own	Home		
	Da :	al Hyg	BeC	17. Father's Name (First, Middle, Las	st)				18. Mother's Nam	ne (First, Middle, I	Maiden Sumam	е)		
2.4	yla	ould to Ment Marked Marked	ို	Frederick J. Mc						argaret I				
W (V	Maryland	d 2 sh th and th and 7 le m treum		19a. Informant's Name/Relationship Charles F. Welch					and Number or Rui		_	State, Zip	Code)	
500	စ် .	Heal Heal tem 2		20a. Method of Disposition	, 31./30	20b. Place	of Disposition	Lee S		Imore, MI	20c. Location -	City or To	wn, State	-
Ü	ē .	Pages ient of int: If i		1 M Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		State Morel	tery, cremator Land Me	morial	⁹⁾ Jan. = 200		Balt:	imore	. MD	
1/15/05	Baltimore,	permit. Pages I and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiens. Internet, or Items 23e or 28e-f show importent: it item 27 le marked other than "neturet", or Items 23e or 28e-f show any injury or other treumatic event, Ite Medical Examination must be notified at once.		21. Signature of Funeral Service Lio)		22. Nar Lemm	ne and Addres	ss of Facility eral Home	of Dula	ney Val	llev.	Inc.	
5				23a. Part the disease, Tco shock, or heart failure. List only		Flas1e aused the death. Do	110 W	 Pado: 	nia Road	Timoniu	im. MD	21093	Approximate	_
=	P	hysician		Immediate Cause (Final		ach line.							Interval Between Onset and Death	
J		/Medical		disease or condition resulting in death)		or as a consequence		-0001	1-1-1-1				Years	-
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pricis	7	ned Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (or as a consequence	Ø 01):							
02	o,	te be executed ysician and te burial-transit	Еха	resulting in death) Last	Due to (or as a consequence	e of):							
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+	x 68	certifica nding ph	/Mec	IF FEMALE:	23c If yes out	come of pregnancy					00.1.0			
3	Вох	death of	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1☐Live bi	irth 2 ☐ Fetal deal ant at time of death		pic pregnancy er <i>(specify)</i>			Mor	e of delive nth	Day Year	
B	O.	that the o ed by the detached	hysi	9 Unknown	9□ Unkno									
2	S, F		by P	Part II. Other significant conditions	contributing to de	eath but not resulting	in the underly	ying cause give	en in Part I.				e cause of death?	
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5	3ec	hasb pe 2 sl	Completed							24a. Was ar autops perform	у р	Vere auto rior to cor leath?	psy findings available npletion of cause of	
-	al B	certificate has rector, page 2		06)						1 ☐ Yes 2	Privo 1		2. No	_
2	of Vital	sicie s certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2 ER/C	Outpatient 3	DOA Oth	er: 4 Nursing H	th (Check only on		r (Canait	a Hasair -	
7	of	After this funeral di	-	27. Manner of Death			. Time of Injury	28c. Injun		28d. Describe ho			111050166	=
3	ior	ath. or: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	on	ii, Day Toai,	N		Yes 2□No					
	Division	after de Directo	Certification:	3 Suicide 6 Could not 4 Homicide determine	a 28e. Place	of Injury - At home, ng, etc. (Specify)	farm, street, fa	actory, office		28f. Location (Sti City or Town	reet and Numbe , State)	er or Rura	l Route Number,	
	-	To the nospite of Attending Priystolen: The law required to the north state described to the Funerel Director: After this certificate has been strompletely filled in by the funeral director, page 2 should	edical Co	(Check only 2 Medical Exe	eminer: On the ba	best of my knowled	ge, death occi	urred at the tin ation, in my o	ne, date and place, pinion, death occur	and due to the ca	use(s) and ma	nner as st	ated. the cause(s)	
	4	o the other		29b. Signature and title of certifier	and manr	ner stated.		29c. License	e number	29	9d. Date signed	(Month,	Day, Year)	-
		X		I foron c	2 Black	Smo		Do	061199		Jan. 16	, 20.	ù 5	
	11	011,		30 Name and address of person wh	n completed caus	e of death (Item 23a	(Type, Print)							
	l	SOURCE		6601 North	Charles	egistrar's Signature	1450m	hast :	21204					_
	5 38	Sta Registr		31. Date filed (Month, Day, Xear) 1	9 2005	Sylvania Sylvania	No. 1							

DHMH 17 Rev 1/2001

ANDER

	State of Maryland / Department of Health and M 1 - State Registrar Certificate of Death	lental Hygiene Reg. Ng2 0 5 0 0 7 2. Date of Death 3. Time of Death
Physician /Medical	1. Decedent's Name (First, Middle, Last) Clara Lily Wright	JANUARY 11, 2005 4:37 P
Examiner	4a. Facility Name (If not institution, give street and number) ST JOSEPH HOSPITAL 4b. City, Town, or Location of Death TOWSON	4c. County of Death BALTIMORE CO
Funeral Director	5. Social Security Number 222–18–2631 6. Sex 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 2 Min.	8. Date of Birth (Month, Day, Year) June 19 1930 9. Birthplace (State or Foreign Country) Maryland
aryland show	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland n/a Baltimore	10d. Inside City Limits 1X∑Yes 2 □ No
fits death with the Maryland ritems 23s or 28s-f show niner must be notified at Funeral Director	Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 21229	10g. Citizen of What Country? United States
036 urs after elf, or ite	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Ovorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Specify Cuban, Mexican, Puerto 1 Yes, Give Year or Dates:	
2 2 2	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 16a. Decedent's Usual Occupation (Give kind of work done during most of work) Ifte. DO NOT use retired) Evangelist	Religion
Maryland 2121: ad 2 should be filed within th and Mental hygiene. 27 is marked other than "; treumatic event, the Mas To Be Comple		e (First, Middle, Maiden Sumame) cnsley
등 일곱었는		al Route Number, City or Town, State, Zip Code) ue, Baltimore, Maryland 21228
Page Page nent o	1 Burial 2 □ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) 1 □ Donation 5 □ Other (Specify)	
Baltimo permit. Pag Dapartment importent: i any injury o once.	4107 Wilkens Avenue	obard Funeral Home, Inc. e, Baltimore, Maryland 21229
8760, sate be executed Thysicien and the burist-transit abunist-transit and the burist-transit and dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or infury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Shoembolism Onset and Death
O. Box 6 ne death certific the attending p thed for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23d. Date of delivery Month Day Year
rds, P., quires that the n signed by uld be detaced by Physical py	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Northead
al Record Tha law require cate has been si paga 2 should I		24a. Was an autopsy performed? 1 Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of dagth? 1 Yes 2 □ No
sion of Vita tending Physician leath. tor: After this certifithe funeral director cation; To Be	examiner?	th (Check only one) ome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Mar palatono + dralysis graft dislodged blood clot 28f. Location (Street and Number or Flural Royte Number, city or Town, State) Grand bits Health Care
DIVI To the Hospital or At within 24 hours after C to the Funeral birect completaly filled in by Medical Certifi	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, the date of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
To the within 2 To the comple	29b. Signature and title of certifier OCME	JANUARY 12, 2005
31	Critical II - (CENTON G	BALTIMORE, MARYLAND, 21201
State Registrar DHMH 17 Rev 1/2001	31. Date filed (Month, Day, Year) 32. Registrar's Signature	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** January 15, 2005 VICTORIA HOLLEY WOODS /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Maryland General Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕅 🛣 55 Director 214-54-4229 SEPT 3, 1949 MARYLAND Usual Residence of Decedent 7 is marked other than "natural", or itams 23a or 28a-f show traumatic event, it a Medical Examinar must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No Director MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6810 PARK HEIGHTS AVENUE 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes = 2XXIvo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 5-0036 Specify: BLACK 1 ☐ Yes 2\X\No Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) llth grade JANITORIAL PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ELMER W. HOLLEY MARY BLACKSTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 Tony Holley/Son 6810 Park Heights Ave., Baltimore, Maryland 21215 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ō 1 X Kurial 2 Cremation 3 Removal from State permit. Page Department o Importent: If sny Injury or 4 □Donation 5 □ Other (Specify) MT ZION CEMETERY 01-21-05 LANSDOWNE, MARYLAND 21. Signature of Euperal Service License 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Mallew 1206 W NORTH AVENUE 23a. Part Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 0 **Physician** /Medical Due to (or as a consequence of): Examiner Sta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a cons wence of): Examine death certificate be executed as the buriat-transit and resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physician/Medical esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) Ö detached 9 Unknown ۵. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 2 No 1 Yes 2 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated. within 2 To the 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTLANDRE MUD 21201 32. Regularar's Signature 31. Date filed (Month, Day, Year) State JAN 1 9 2005 Registrar

		1	For State Registrar	State of Maryland	-	artment of H			giene	05	01089
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ıth		3. Time of Death
	Physicia		Liguori Thelma	Zukas				JANUARY	15.	Year 2005	10:45AM
	/Medic Examin		4a. Facility Name (If not institution, give s		ter	4b. City, Town, or			4c. County	of Death	imore
			5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year	If Under 24 I	Hrs. 8. Date of Birth	n	9 Birthola	ace (State or Foreign
	Funeral Director			M 2∑F 68	Yrs.	Months Days		Ain. (Month, Day	, Year) , 1936	Count	ry)
		-	Usual Residence of Decedent	00				mar 07	,1930	Mary	rand
	/lang		10a. State 10b. County	10c. City	Town or Lo	cation				10	d. Inside City Limits
	Mar Hed	to	MD. N/A	Ва	1time	ore					1 □Yes 2X No
	r 28s	Director	10e. Street and Number			10f. Zip Code	-:-		10g. Citizen of \	What Count	ry?
	13a o	D E	3037 Linwood Av	enile		21234			United	i Sta	tas
	deat	Funerai		2. Was Decedent Ever in U.S Armed Forces?	S. 13.			? (Specify Yes or No- uerto Rican, etc.)	14. Rac	e - America	n Indian,
9	after or its		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give	ĺ	i les, specily cuba i □ Yes 2X No	Specify:	uerto Ficari, etc.)	l	r. Whie.e	
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21215-0036	within 72 hours after death with the Maryland nne. ttan "Latural", or Itams 23a or 28a-f show ttan "Medical Examiner must be notitied at	Completed	15. Decedent's Educ (Specify only highest grade		(Give	tent's Usual Occupa kind of work done of	furing most of	working	16b. Kind of B		,
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N	be filed within 72 hours after death with the Marylan ital Hygiene. Id othar than "natural", or Itams 23a or 28a-f show othar than "natural", or Itams 23a or 28a-f show event, the Medical Examiner must be notified at		12 17. Father's Name (First, Middle, Last)			Jan Olli		Name (First, Middle,	Credit		on
Baltimore, Maryland	should be fand Mental Family markad of iumatic evaluations	o Be	Robert Watson					a Lubert		10)	
<u></u>	s 1 and 2 should be f Health and Mental itam 27 is markad othar traumatic ev	ř	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailir			r Rural Route Numbe		State, Zip (Code)
Z S			Mark Zukas/ Son			-		nue, Bal	-		
ē,	of Health of Health litam 27 i		20a. Method of Disposition	20b. PI	ace of Dispo	sition (Name of		Date	20c. Location	City or Tov	vn, State
JU O	ages ant of it: If i		1 ☐ Burial 2 X Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	-	natory or other place ake Crem		an 18, 2005	Belts	vill	e, MD.
Ħ	permit. Pages 1 Department of H Important: If its any injury or ot once.	1	21. Signature of Funeral Service License					200.)			,
ä	permi Depa Impo any ir		> & Hali	el	Q (rematio 717 Gre	n and en Pa	Funeral stures D	Alter r. Bal	nati timo	ves re. MD.
П			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death	. Do not ent	er the mode of dying	g, such as car	diac or respiratory ar	rest,		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):						
	Examinet .		Sequentially list conditions,								
	ed sit	Examine	Sequentially list conditions, if any, Isaams to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a consequ	enga utja						
_	The law requires that the death centificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	хап	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):					_	
8760,	be e sician buria	a E									
687	icate phys	edicai									
Вох	eath certific attending p I for use as I	/W	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar		_			23d. Da	te of deliver	γ
ă	death s atte d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 No	1 Live birth 2 Fetal 4 Pregnant at time of de]Ectopic pregnancy] Other <i>(specify)</i>			Mo	onth (Day Year
0	at the de by the a tached	hys	9 Unknown	9□ Unknown		-					
O.	es tha igned be del	by P	Part II. Other significant conditions cor			nderlying cause give	en in Part I.	23e. Did to	obacco use con	tribute to the	e cause of death?
Records,	w require been sig		CHRONIC OBSTRUCTIV	E LUNG DISEASI	<u> </u>			1 X Y	res 2□No	3 Proba	ıbly 4 □Unknown
သွ	law re	plet						24a. Was	an 24b.	Were autop	sy findings available
	The tage has	Completed						perfo	rmed?	death?	
Vital	ician: certifica rector, p	Bec	25. Was case referred to medical examiner?				26. Place of	Death (Check only o			
	diis	2	1 ☐ Yes 2 X No	lospital: 1 X Inpatient 2 🗆	ER/Outpaties	nt 3□ DOA Othe	er: 4 ☐ Nursir	ng Home 5 - Resid	dence 6 🗆 Oth	ner (Specify,)
n of	fter nen		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injun Worl		28d. Describe h	now injury occur	red	
Sio	Attanding r death. actor: After by the funer	catl	2 Accident investigation			M 1 🗆	Yes 2 ☐ No				
Division	in the s	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, st	eet, factory, office		28f. Location (S City or Tox		oer or Rural	Route Number,
	pitai ours a aral l		29a. Certifier 1 Certifying Physics	sicien: To the best of my know	vladae deat	h occurred at the tim	ne date and n	lace and due to the	cause(s) and m	anner as ets	ated
	To the Hospitai within 24 hours a To tha Funaral I completely filled	Medical	(Check only 2 Medicel Exami	ner: On the basis of examinat and manner stated.	ion and/or in	vestigation, in my of	pinion, death o	occurred at the time,	date and place,	and due to	the cause(s)
	Fo th within Fo th	Me	29b. Signature and little of certifier	// _		29c. License	e number		29d. Date signe	d (Month, E	Day, Year)
				mund ot	13	D 3	7254		i / i	5/0	5
	/λ		30. Name and address of person who co	empleted cause of death (Item	23a) (Type,	Print)					
	V /		BOON P. LIM. M	.D., 7601 O			TOWSO	N, MARYL	AND 21	204	
	Sta	ate	31. Date filed (Month, Day, Year)	Registrar's Signal					4		
	Regist	rar	JAN 1 9 2005	Blacker S.	REPOR	REL!					

0			For State Registrar	State of M	aryland	-	rtment			and M	ental Hy	/giene Reg. No	/11115	01090
	Physicia /Medic	an	Decedent's Name (First, Middle, L EDWARD	ast)		ZORN	, SR.				2. Date of D Month JAN .	17,2	2005	3. Time of Death $5:00p^{M}$
版-	Examin	er	.,,	UE Sex 7. As	ge (In yrs. las		If Under 1	LTI	MORI	Ξ	8. Date of B	irth	Cour	place (State or Foreign
	Director		214-16-5931 Usual Residence of Decedent 10a. State 10b. County	X	8 2	Yrs.					SEPT.	16	,1922 M	ARYLAND Od. Inside City Limits
	with the Mar	Director	MD. N/A			BALT	I MORE	ode	1224			10g. Cit	tizen of What Cour	
900	d within 72 hours after death with the Maryland jone. Ir then "naturel", or items 23e or 28e-f show It a Medical Evaculation at the redified at	d by Funeral Director	3502 FAIT AVEN 11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Wildowed 4 □ Divorced	12. Was Decedent Armed Forces 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	, _{No} 1943–	46	☐ Yes 2X	nt of His Cubar	Specify:		ecify Yes or N Rican, etc.)			can Indian, etc.
21215-0036	i within 72 piene. r then "na	Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4or		(Give life. L	lent's Usual kind of work DO NOT use MANAC	done d retired,	luring mos	t of worki	ng		aind of Business/In	
Maryland	be file	To Be C	17. Father's Name (First, Middle, Las ANDREW GEOF 19a. Informant's Name/Relationship	RGE ZORN		10h Mailir	an Address (Street	LI	LLIA		GGS	n Sumame) or Town, State, Zip	Code)
	1 and 2 Health a em 27 is		EDWARD M. ZORN	JR./SON	20b. Pla	1311		E	ROAD	, PYI		LE,	MARYLAN	D 21132
Baltimore,	permit. Pages Department of Importent: If its eny injury or o		1 Burial 2 Commation 3 14 Donation 5 Other (Special Signature of Funeral State Lice	cify)		VIEW	CREM	Addres	ORY	ĔR I	NC. I	UNE	TIMORE, RAL HOM ALTO.,M	MARYLAND E D. 21224
760,	te be executed / Medical / Medical Examiner Fransit Fransit	ical Examiner	23a. Part1. Enter the disease, or conshook, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a b. Que to (or a c.	ed the death. line. S a conseque s a conseque s a conseque	ence of):	er the mode	of dying Ma IU	livi La	ardiac o	r respiratory	arran	Tuesse	Approximate Interval Between Onset and Death
O. Box 687	death certifica e attending ph id for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal o	death 3[]Ectopic pred] Other (spec						23d. Date of deliv Month	ery Day Year
٥	es ngi pe	by	Part II. Other significant conditions	contributing to death	but not result	ting in the u	nderlying ca	use give	en in Part I	l.			use contribute to t	he cause of death?
al Records,		Completed									pe 1 ☐ Yes	opsy formed? 2 Z No	prior to co death?	opsy findings available ompletion of cause of
on of Vital	Attending Physicien: The r death. sctor: After this certificate has yether tuneral director, page	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Magner of Death 1 Natural 5 Pending 2 Accident investiga	Hospital: 1 Inpa 28a. Date of In (Month, D		R/Outpatier 28b. Time <i>o</i> Injury		c. Injun	er: 4 🗆 N	ursing Ho	h <i>(Check onl</i> me 5 72 Re 28d. Describ	sidence	6 Other (Special occurred)	(y)
Division	P 등 는 L	Certification;	3 Suicide 6 Could no 4 Homicide determin	building,	etc. (Specify)					l.	City or T	own, Stat		
)	To the Hospitel within 24 hours a To the Funeral Completely filled in	Medicai	29a. Certifier (Check only one) 2 Medical Example 29b. Signature and title of certifier	Physician: To the besaminer: On the basis and manner	of examination	rledge, deat on and/or in	vestigation,	n my o	ne, date ar pinion, dea e number	nd place, ath <i>o</i> ccuri	and due to the	e, date an	s) and manner as s nd place, and due t ate signed; (Month,	to the cause(s)
\	Mitt		Saeut.	OUR no completed cause of	death (Item	3a) (Type,	Print)	03	380	7-1	3	1/	18/05	
	St Regist	ate trar	DBM A 31. Date filed (Month, Day, Year) JAN 197	761 2. Regis	strar's Signatu	7961	and	M	7 (5	CV.	Mme	n	MYJ	1009

			. 10000	State of Maryland / I	Department of Health and	Mental Hygier	ne
		•	For State Registrar	olato of maryland?	Certificate of Death	Reg. 1	21115 11191
7			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
P	hysicia /Medic		ROOSEVELT	ALMOND		JAN 1	Pay Year XI3 AM
E	/Medic Examin		4a. Facility Name (If not institution, give st		4b. City, Town, or Location of Dec		4c. County of Death
			NORTHWEST HO	SPITAL	RANDAUSTO		BALTIMORE
	ineral		5. Social Security Number 6 Sex	7. Age (In yrs. last bi	rthday) If Under 1 Year If Under 24 Hi Yrs. Months Days Hours Mi		9. Birthplace (State or Foreign Country)
Dii	rector		Usual Residence of Decedent	M 2□F 62	115.	02-20-	42 IIID
land	Mo to		10a. State 10b. County	. 10c. City, Tow	n or Location		10d. Inside City Limits
Man	led by	ţo	MD Raltu	nore	Owing Mills		1 ☐ Yes 2 No
th the	or 28	irec	10e. Street and Number		10f. Zlo Code	10g. (Citizen of What Country?
death with the Maryland	23a	Funeral Director	4415 WUNFIELD	Drive	21117		<u> 484</u>
er de	Items	nue	2	2. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc.
urs aft	P, or	byF	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 Yes 2 No Specify:		Specify: RIMK
within 72 hours after ene.	d other than "netural", or items 23a or 28a-1 show event, it is Modical Examinational barnoilitied at		15. Decedent's Educ	ation 16a	Decedent's Usual Occupation	16b.	Kind of Business/Industry
thin 7	Med 'r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of w life. DO NOT use retired)	Orking	Pari Allantia
C C I C I L I L I L I L I L I L I L I L	it, II		1CT GRADE	4 YRS	Manager	- F	XU AHUNTIE
ylarıq ould be fi Mental H	ed of	Be	17. Father's Name (First, Middle, Last)		18. Mothers N	ame (First, Middle, Maid	lo a a a a a a a a a a a a a a a a a a a
should nd Men	marked other than matic event, the M	<u>م</u>	19a. Informant's Name/Relationship (Typ	e. Print) 19t	D. Mailing Address (Street and Number or I	Bural Boute Number Cit	y or Town State Zin Code)
15 C	27 Is	(heaveling M Alr	amd(NiFe) 4	415 MUNIFIELD Dri	ie Ouring	SMILL MD 21117
s 1 and 2	If item 27 Is marke or other traumatic	1	20a. Method of Disposition	aama ta	of Disposition (Name of pry, crematory or other place)	Date 200	Location - City or Town, State
partmort pages Department of h	int: If		1 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	moval from State		16-05 1	woms Mills MD
ormit.	Importent: any injury once.		21. Signature of Funeral Service License	ů -	22. Name and Address of Facili	aughnes	regretimenal six.
0 % č	5 2 3		Vaught:	D	87:28 Luberty K	ond, Kurda	110town, M.D, 21133
	94		shock, or heart failure. List only on	ations that caused the death. Do cause on each line.	not enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
	sician edical		Immediate Cause (Final disease or condition resulting in death)	ATHEROSCLEPOTI		- DISEASE	,
	miner			Due to (or as a consequence	MELLITIK		i lan er
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cuted	fransi	Examiner	Cause (Disease or injury that initiated events				
6 be exe	hysician and fhe burial-fransit		resulting in death) Last	Due to (or as a consequence	of):		
. BOX BB/BU, death certificate be executed	physics the t	dical	d.				
D X D	attending ph	/Me	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregnancy			23d. Date of delivery
death	d for u	Physician/Med	in the past 12 months?	1☐Live birth 2☐Fetal death 4☐Pregnant at time of death	n 3 □Ectopic pregnancy 5 □ Other (specify)		Month Day Year
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ecords, P.O.	been signed by the should be detached	ру Р	Part II. Other significant conditions cont	ributing to death but not resulting	in the underlying cause given in Part I.		o use contribute to the cause of death?
cords w requires	een s	Completed	LYMPHOMA			1 Tes	2 No 3 Probably 4 Unknown
5 ± 8 × 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 ×	has b	nple				24a. Was an autopsy performed:	24b. Were autopsy findings available prior to completion of cause of death?
The The	icate ha					1 ☐ Yes 2 🛣	No 1 Yes 2 No
Or Vital Physician: 1	s certificate has birector, page 2 s	o Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	ospital: 1 Inpatient 2 ER/0	Othor	eath (Check only one) Home 5 Residence	C Clothan (Conside)
P Phy	eral d		27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injury at	28d. Describe how in	
ath.	r: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Fear)	Injury Work? M 1 ☐ Yes 2 ☐ No		
I or Attending after death.	irecto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
Dital o	aral D						
Hos 24 ho	Fune etely f	edical	29a. Certifier (Check only one) Certifying Phys Certifying Phys Certifying Phys	er: On the basis of examination ar and manner stated.	e, death occurred at the time, date and pla nd/or investigation, in my opinion, death oc	ce, and due to the cause curred at the time, date a	i(s) and manner as stated. and place, and due to the cause(s)
To the Hospital or Attending within 24 hours after death.	To the Funeral Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier		29c. License number	29d. [Date signed (Month, Day, Year)
			1 Xonith	M. M	D589 33	5	m 17,2005
D			30. Name and address of person who cor	nplets d c use of eath (Item 23a)			
法						When the Actual Street	A TOTAL A STREET OF THE STREET
4	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	D COURT RD R	ANDAUSTOL	NN, MD 21133

05-00362 B.K.S JOHN BUTLER

Amend item#17,20b-c, perfil G039, 1720705 II Hoolth and Montal Hygione

.IIN	DOTTER	-	For State Registrar	State of Mary		artment of Hertificate of L		ental Hygie _{Reg.}	/ 11115	01092
	Physicia		1. Decedent's Name (First, Middle, Las		<i>Q</i> .			2. Date of Death	Day 2005 Year	3. Time of Death 0956 AM
	/Medic	al -	JOHN As Facility Name (If not institution, give	BYRON e street and number)	104	TLER 4b. City, Town, or	Location of Death	JAN. 13	4c. County of Death	
	Examin	er	4a. Facility Name (If not institution, given SINAI HOSPITAL			BALTIMO	Location of Death)RE CITY			IA
	Funeral Director	- 1	5. Social Security Number 6. S 215-76-0171 1 Usual Residence of Decedent	ex 7. Age (la Age (la	n yrs, last birthday) 3 8 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, You AUG-29)	ear 1966 9. Birth	nplace (State or Foreign intry) ARY LAND
	yland		10a. State 10b. County	10	Oc. City, Town or Lo			0		10d. Inside City Limits
	Ba-fsl	ector	YARYLAND N	A			IMORE	CITY	. Citizen of What Cou	1 X Yes 2 No
	with th		10e. Stribet and Number 2601 SHIR	IFIL AVE	NUE	10f. Zip Code	2121:	5	USA	
	ems 2	Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	or in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	ncan Indian,
36	tiled within 72 hours after death with the Maryland Hygiene. tther than "natureli", or items 23a or 28a-f show ent, the Medical Enanther must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗖 No	Specify:		Specify:	LACK
215-0036	"naturai",	eted	15. Decedent's E	fucation de completed)	(Give	dent's Usual Occupa	luring most of worki	ing 16	b. Kind of Business/I	
2121	within ene. than "	To Be Completed	Elementary/Secondary (0-12)	3 College (1-4or 5+)	life.	DO NOT use retired	,		10BILE C	ARWASH
d 2	e filed al Hygi other vent, I	3e Cc	17. Father's Name (First, Middle, Last	tthews	2		18. Mother's Name	(First, Middle, Ma	iden Sumame)	
Maryland	permit, Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, Ite Medical 0009.	Tof	JOHN MA	TTHIAS	BUTLE 100 Mail	-	LEST2		Eity or Town, State, Z	
Mai	nd 2 sh lith and 27 is n r traun		DERRICK M. BUT.		1					MD 21208
ore.	es 1 a of Hea of Hea if item or othe		20a. Method of Disposition 1		20h Place of Diene	osition (Name of matory or other place	θ)	Date 20	c. Location - City or loodlawn,	fown, State
Baltimore,	it. Pag rtment rtant: njury c		4 Donation 5 Other (Special 21. Signature of Funeral Service Lice	y)	1 da Do d	2. Name and Address	ne. 01 - 6	20-05	P France	HARVIAL
Ba	permit. Depart Import any inj		Wetrich	N. Will	iams =	1035PN	H H DE	AVE. X	BALTO, M	2AL HOME 10.21217
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused th one cause on each line.	e death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arrest	t,	Approximate Interval Between Onset and Death
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Hyperten	The state of the s	lunscle	olu Caro	hovuseeld	n 1909	
	Examiner		Sequentially list conditions,	b						
	peti nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence of):					
o.	ficate be executed physician and s the burial-transit		that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
68760.	icate be physicia s the bur	edical		d						
Box	death certi e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tin	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	ivery Day Year
ds. P.O	quires that the signed by ald be detacted.	by	Part II. Other significant conditions	contributing to death but	not resulting in the t	underlying cause giv	en in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	the cause of death?
Division of Vital Records.	The law recate has bee page 2 shot	Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of 2 \(\text{No} \)
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	- X	oth Oth	0.5	h (Check only one)		4.1
Ç	ding Physician: After this certific funeral director,	n: To	1 XYes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day)	- I	INT 3 DOA	y at	28d. Describe how	ce 6 Other (Special or occurred)	my)
ion	ttanding I death. ctor: After y the funer	catio	1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not	n .		M 1 🗆	Yes 2 □ No	00/ 1	at and Number on Di	and Proute More has
) į į	i or Att after d Direct	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		r - At home, larm, si (Specify)	treet, factory, office		City or Town,	et and Number or Ru State)	rai noute Number,
	To the Hospital or Attanwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exe	hysician: To the best of miner: On the basis of e and manner state	xamination and/or i	th occurred at the tir nvestigation, in my o	ne, date and place, pinion, death occur	and due to the cau	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and attend of cartified	M		29c. Licens	o number C.M.E	290	JAN 16,	2005 ^{Year)}
đ	21		30. Name and address of person who	mr etad cause of dea		STREET,	BALTIMORI	E, MARYLA	ND 21201	1
	St Regist	ate rar	31. Date filed (Month Day, Year)	2005 32. Figistrar	s Signature	porte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#8 perFH C839 1/20/05 CS item1perCS

State of Maryland / Department of Health and Mental Hygiene 0 5 1 - For State Registrar Certificate of Death Req. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 10:00 A M 2005 Deborah Bridgeforth 01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gildrist Hospice Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day Year)

When the Days Hours Min. (Month, Day Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 215-78-8285 1 M 2 F 44 Yrs. MD **Director** Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or items 23a or 28a-f show the Medical Exertinet must be notified at MD Baltimore 1 ¥Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2/229 400 Kevin Koad Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 Mo. If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: BIACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) +tomemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental P permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked any injury or other traumatic every space. Bridgeforth Doretha Bradley James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 Kevin Road Baltimore MD 21229 Diretha Bradley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State DI. 22.05 WODDIAWN, MD WOODLAWN 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funecal Service Licensee 27. Name and Address of Facility
Volume (. Greene Funerai Services
515/Baltimore NATIONE) PIRE Baltimore MD 21229 lau Approximate Interval Between Onset and Death 23a. Part1. Enjor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Squanous cell cancer of head Ineck **Physician** months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician for use as the buriar Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. P 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by of Vital Records, 1 1 Yes 2 □ No 3 □ Probably 4 □ Unknown After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform, rmed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Wither (Specify) 101 1 ☐ Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division 5 Pending Injury 1 Natural 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JANUARY 12 2005 D 58303 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARMON CHARLUES, MO GOON CHAMES ST BATINDIES NO ZIZOY 31. Date filed (Month, Day, Year) State

Registrar

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JAN 2 0 2005

			For State Registrar	State of N	Maryland / Dep Ce	artment of		and Mental Hy	giene 005	01094
	Dhuaiai		1. Decedent's Name (First, Middle, Las	t)				2. Date of De Month	aath Day Year	3. Time of Death
	Physicia /Medic		Edna R. Bowma					Januar	y 10, 2005	10:45 P.M
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town,		f Death	4c. County of Dea	
	5		Franklinwood Nurs 5. Social Security Number 6. S		Age (In yrs. last birthday	Baltime If Under 1 Year		24 Hrs. 8. Date of Bir	Baltimor	
ı	Funeral Director			□M 2-F	85 Yrs.	Months Day	s Hours	Min. 8. Date of Bil (Month, Da	y 11,1919 Tex	thplace (State or Foreign ountry)
	pu ,		Usual Residence of Decedent		100 City Town out			TORUM	¥ 11 4 1213-1326	
	shov	'n	10a. State 10b. County Maryland Baltimore	2	10c. City, Town or L Baltimore	ocation				10d. Inside City Limits 1 ☐ Yes 2 XNo
	28a-f	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	3a or	ī	4300 Bedrock Circ	le			236		United Sta	
	be filed within 72 hours after death with the Maryland ntal Hygiene. ad other than "natural", or Itams 23s or 28s-f show evant, itte Modical Exertities inval by coulded at	Funeral Director	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S. 13.	Was Decedent of	Hispanic Original	gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - Ame Black, Whit	
36	or its	y Fu	1 Never Married 2 Married	1 ☐ Yes 2∑ If Yes, Give	No	1 ☐ Yes 2X N		, ruono moan, etc.,	Specify: Whi	
21215-0036	hours tural',	ed by	3 Widowed 4 □ Divorced	Year or Dates		edent's Usual Occ	unation			
7	in 72	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Giv	e kind of work don DO NOT use reti	upation e during most red)	of working	16b. Kind of Business	vindustry
212	d within giene. ir than "	omo	Elementary/Secondary (0-12)	College (1-40		retary			Church	
	al Hygie I other vant, II	Bec	17. Father's Name (First, Middle, Last)					r's Name (First, Middle	, Maiden Sumame)	
Maryland	2 should be and Mental Is marked o	To	Neal Costan				1	lie Moore		
Jar	s 1 and 2 should f Health and Men item 27 Is marks othar traumatic		19a. Informant's Name/Relationship (1	Type, Print)				r or Rural Route Numb Ltimore Md	er, City or Town, State, .	Zip Code)
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Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar once.		1 Burial 2 Cremation 3 . 4X Donation 5 Other (Specify		20b. Place of Disp cemetery, cri			anuary 10		ington DC
ij	nit. Partme ortan injur		21. Signature of Honeral Service Licen					Columbia D		nigeon be
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Н			23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that caus	ed the death. Do not er					Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to kir a	as a consequence of):					
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7	nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Under, in Cause (Disease or injury	Dagi		Maso	natur	diseas	•	
7	execun and ial-tra	Exal	that initiated events resulting in death) Last	Due to (or a	s a consequence of):	0.630	~ , () \	0.0.17	•	
8760,	certificate be executed nding physician and use as the burial-transit	lical		d						
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Вох	death ce e attendi	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	□Ectopic pregnar	ісу		23d. Date of de Month	livery Day Year
o.	the de y the a iched f	ysic	1 ☐ Yes 2 ZeNo 9 ☐ Unknown	4∐Pregnant 9☐ Unknown		Other (specify)				
٥.			Part II. Other significant conditions of	ontributing to death	but not resulting in the	underlying cause	given in Part I.	23e. Did	tobacco use contribute to	o the cause of death?
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000	law rek as bee 2 shoi	plete	Emphyson	N A				24a. Was		utopsy findings available
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ita	iician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?				26. Place	of Death (Check only		
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		lon:	27. Manner of Dath 1 Natural 5 Pending		njury 28b. Time Day Year) Injury	W	juryat fork? ∐Yes 2 ∐1		how injury occurred	
Division	ten deatl tor: the	ertification:	2 Accident Investigation 3 Suicide 6 Could not be		Injury - At home, farm, s				Street and Number or Ri	ural Route Number.
Ď	in Dirt	erti	4 Homicide determined	building,	etc. (Specify)				wn, State)	,
	To the Hospital or At within 24 hours after or To the Funeral Dirac completely filled in by	edical C	(Check only 2 Medical Exam	niner: On the basis	of examination and/or i	th occurred at the nvestigation, in my	time, date and opinion, deat	d place, and due to the th occurred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner	orateu.	29c. Lice	nse number		29d. Date signed (Mont	th, Day, Year)
	ل ≱ ت ۲)()(,,	_	MD		5346	2	1/12/05	
	^		30. Name and addess of person who	completed cause o						
	2		Jude Muneres	MD	7845	DOWNAC	d Re	od Glen	Burnie, M	121061
	Sta	-	31. Date filed (Month, Day, Year)							
	Registr	ar	JAN 2 0 :	2005	ever &	hook				

			State of Maryland / Dep	eartment of Health and Mertificate of Death	Mental Hygie	211115	01095
		,	Decedent's Name (First, Middle, Last)		2. Date of Death Month		3. Time of Death
	Physici /Medic		Helen M. Banks		January	17, 2005	12:31 PM
	Examin	er	4a. Facility Name (If not institution, give street and number) Greater Baltimore Medical Center	4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 M 2 AF 8 Yrs.	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birth Cou	place (State or Foreign ntry) VA
	yland Now		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or I				10d. Inside City Limits
2	Ba-f st	ctor		allstown			1 □ Yes 2 □ No
161	death with the Maryland rms 23a or 28a-f show rmust be motified at	Funeral Director	11 Spinners Court Apt. 1A	104. Zip Code 21133		Citizen of What Cou	
H	<u> </u>	b	11. Marital Status 1 □ Never Mamied 2 □ Married 3 ▼Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 XNo Specify:	Decity Yes or No- Di Rican, etc.)	14. Race - Ameri Black, White, Specify: B	
2	Maryland 21215-0035 d 2 should be filed within 72 hours af th and Mantal Hygiene. t7 is marked other then "natural; or traumatic event, it a hydical Exam	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	king 16t	b. Kind of Business/Ir	dustry
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5	nd .	3e C	17. Father's Name (First, Middle, Last)		ne (First, Middle, Main		
BAN	laryland 212 2 should be filed within and Mental Hygiene. Is marked other then sumatic event, ILLIN	To Be	Watson Hamnaton	/ Annie	2 Blue		210/0
	C 2 44 F		Mary Cunning nam/Daughter 88		ircle#21		VILLE MD
	nord Pages in of h		20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 Removal from State ' 4 Donation 5 Other (Specify)	position (Name of emalory or other place)	22.05 R		
:	Baltimore, permit. Pages 1 a Department of Hec Importent: If tem any injury or othe once.			Name and Address of Facility Managhn & Griene 5151 Baltimore Nati	Funeral S	enices	10 21229
	STATE OF		23a. Part 1. Enler he disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			MITTING I	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	1-175			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				140
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	4			1 1
1	60, observed sician and burial-transit	Examiner	that initiated events c.				
	ate ate		Due to (or as a consequence of): d			Щ	
(Cords, P.O. Box 6i wrequires that the death certific been signed by the attending p should be detached for use as	Physician/Medical	IF FEMALE: 23b Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3			23d. Date of deliv	ery
1	Division of Vital Records, P.O. Box or a standing Physician: The law requires that the death certain death. Director: After this certificate has been signed by the attendin in by the funeral director, page 2 should be detached for use.	sicia		☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
1	hat the		Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to t	he cause of death?
	rds, quires an sign uld be	ed by			1 🗆 Yes	2 □ No 3 □ Pro	bably Unknown
	eco lawre las bee	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
	Vital Rec sicien: The law certificate has b irector, page 2 s		_17		performed 1 ☐ Yes 23	death?	2 □ No
	Vit	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient	0.1	th (Check only one) ome 5 Residence	a 6 Oother (Speci	ful
·	n Of ng Phy Iter thi	on: T	27. Manner of Death 1 Manual 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending (Month, Day Year)	of 28c. Injury at	28d. Describe how i		77
	ISIO ttendi death. stor: A	icati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	28f Location (Street	t and Number or Rur	al Pouto Alumbas
i	Divi	Certification;	4 Homicide determined building, etc. (Specify)		City or Town, S	itate)	
	Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, de: 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as a and place, and due t	stated. to the cause(s)
	To the within To the comp	×	29b. Signature and title of certifier	29c. License number		Date signed (Month,	
			30. Name and address of person the completed cause of death (Item 23a) (Type Y AO - Y AO - Z H U . 6565 N . Charles F	フ. (ノン 5 6 5 a. Print)	4 70	innay 1	5,2005
	5		YAO-140 ZHU, 6565 N. Charles A	1203. By 1+ imal,	mD 2120	4	
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Regist DHMH 17 Rev 1/2	-6	31. Date filed (Month, Day, Year) JAN 2 0 2005 32. Registrar's Signature	books			
			ORIGII	VAL			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Ethel Lee January 10, 2005 8:10 p /Medical 4e. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Deeth Examiner Southern Maryland Hospital Prince Georges Clinton 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days 1 □ M 2 2 F 579-30-9755 Director 93 August 6, 1911 South Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Heetith and Mental Hygiene. Int: If item 27 is marked other then "neturel", or items 23s or 28s-f show 10b. County 10c. City, Town or Location 7 is marked other then "neturel", or items 23s or 28s-f show traumatic event, the Medical Expansion must be notified at 10d. Inside City Limits ty Yes 2 □ No Funeral Director Prince Georges Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1802 64th Avenue 20785 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: African American Specify: þ 3

Widowed 4

□ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lemuel Little ဥ Rosa Harper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances E. Dickens- Daughter 1802 64th Avenue Cheverly MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: if it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donetion 5 ☐ Other (Specify) Ft. Lincoln Cemetery 1/14/2005 Brentwood MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood MD 20722 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Anemia Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) Yes 2 No 9 Unknown 9 Unknown has been signed by se 2 should be detac Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed page certificate 2 No 1 Yes To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 hpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director; After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) npletely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D00 MD 39 Name and address of person who completed cause of death (Item 23a) (Type, Print) brilke 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

9	Pļ /
Division of Vital Records P O Box 68760	Hospitel or Attending Physicien: The law requires that the death certificate be executed

		For State Registrar	State of Ma	nt in Black In aryland / Depa Cea		lealth and N	nental Hyg	iene 005	01097
Physicia /Medic	100	Decedent's Name (First, Middle, Last Melvin Black	")				2. Date of Deat Month JANUA		3. Time of Death 5 12 .00 Am
Examina Funeral Director		4a. Facility Name (If not institution, give Mercy Hospice 5. Social Security Number 6. Security Number		e (In yrs. last birthday) 68 Yrs.	Baltim		8. Date of Birth (Month, Day, Oct 17,	Year) C	,
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland n/a		10c. City, Town or Lo					10d. Inside City Limits 1X Yes 2 □ No
after death with the Maryland or items 23s or 28e-f show miner must be notified at	al Director	10e. Street and Number 3918 Wabash Avenue	2		10f. Zip Code 212	15	1	Og. Citizen of What C United	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Inpendentent of Heath and Should Hygiene. Inpendenti if item 27 is marked other then "neturelt, or items 23s or 28e-1 show eny injury or other treumetic event, the Medical Examinar must be notified at once.	by Funeral	11. Marital Status 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2	No l	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🗓 No	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: Af	
should be filed within 72 hours about be filed within 72 hours not Mental Hygiene. In marked other then "neturel", umetic event, the Medical Example.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	pation during most of work d)	ting	16b. Kind of Business	ŕ
Mental Hygi Mental Hygi arked other etic event,	To Be Co	17. Father's Name (First, Middle, Last) Joe Black				18. Mother's Nam Susan	e (First, Middle, I Mae Gay	Maiden Sumame)	
1 and 2 she Health and em 27 is m		19a. Informant's Name/Relationship (7 Rosa Mae Black – C		3918	Wabash A	Avenue, B	altimore	, City or Town, State, , Maryland 20c. Location - City o	21215
permit. Pages Department of Importent: If it eny injury or o	20a. Method of Disposition 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Liceusee 20b. Place of Disposition (Name of cemetary, crematory or other place) Bayview Crematory 22. Name and Address of Facility Hubbard Funeral H								Maryland
Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or come shock, or heart failure. The tonly strength of the cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a Due to (or as						Pland 21229 Approximate Interval Between Onset and Death
death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical Exa	resulting in death) Last	d23c. If yes, outcome	2 Fetal death 3	□Ectopic pregnance	,		23d. Date of de	llivery Day Year
0 0 0	by Physic	1 Yes 2 No 9 Unknown Part II. Other significant conditions co	9□ Unknown		Other (specify)	ven in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?
The law requi ate has been s page 2 should	Completed						24a. Was a autops perform	y prior to death?	utopsy findings available completion of cause of
ending Physicien: The sath. or: After this certificate he funeral director, pag	sation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation			of 28c, Injur Wor	er: 4 🗆 Nursing Ho		e) ence 6 Other (Spe w injury occurred	acity) haspice
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	building, et				City or Towr		
the Hosp hin 24 hou the Fune mpletely fi	Medical	29a. Certifier (Check only one) 1. Certifying Ph 2 Medical Examone) 29b. Signature and title of certifier	ysician: To the best iner: On the basis of and manner sta	of my knowledge, deat f examination and/or in ated.	th occurred at the timestigation, in my castigation, in my castigation.	pinion, death occur	red at the time, da	ate and place, and du	s stated. e to the cause(s) th, Day, Year)
T will		· Drh	A-	danah (lan 00a) (T.	DH	0854		i a	2005
1		30. Name and address of person who of the control o	va 301	ST Pau ar's Signature		llimore r	nd. 2	1200	h
Sta Registr		JAN 2 0 20		w de de	realis				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) GORDON Μ. BETZ 8:27 P.M 01 18 - 2005 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death HOSPICE OF BALTIMORE GILCHRIST CEN. TOWSON BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10-15-1925 9. Birthplace (State or Foreign 6. Sex Days **XX**M 2□ F Months Hours 214-20-6418 79 Yrs. MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County MD. BALTIMORE BALTIMORE 1 Yes XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8114 RIDER AVENUE 21204 U. S. A. 12. Was Decedent Ever in U.S. Armed Forces? VIXYes 2 □ No If Yes, Give Year or Dates: 1952 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married XX Married 1950-1 ☐ Yes 2 💢 💥 o Specify: WHITE Specify. 3 ☐ Widowed 4 ☐ Divorced 1952 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry PLANT MANAGER Elementary/Secondary (0-12) College (1-4or 5+) **PROFESSIONAL** ENGINEER WESTERN ELECTRIC **PLUS** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) JOHN MORRIS BETZ ANN MARIE DIGGS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MARY ELIZABETH BETZ (WIFE) 8114 RIDER AVENUE, BALTIMORE, MARYLAND, 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 01-25-2005 PARKVILLE, MARYLAND PARKWOOD CEMETERY 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1050 YORK ROAD RUCK TOWSON FUNERAL HOME, INC. R. N. Ruth TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death dieta Causa (Final

Pnysician /Medical **Examiner**

use as the burial-transit

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

BETZ, GORDON

Physician

/Medical

Examiner

Funeral

Director

or 28a-f shov

Items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23s any injury or other traumatic event. The Madical Examinat must once.

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Completed by Funeral

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with the Maryland

disease or condition	1 1 1 1	1400	00313			gears
resulting in death)	Due to (or as a consec	quence of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease on injury	b. Due to (or as a consec	quence of):				
that initiated events resulting in death) Last	C. Due to (or as a consect	quence of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 \(\) Live birth \(2 \) Fet 4 \(\) Pregnant at time of 9 \(\) Unknown	al death 3 □Ectopi	c pregnancy (specify)		23d. Date of de Month	livery Day Year
Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlyin	ig cause given in Part I.	23e. Did tobacc		o the cause of death? robably 4 □Unknown
				24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of 2 No
25. Was case referred to medical			26. Place of De	eath (Check only one)		10
examiner? 1 ☐ Yes 2 XNo	Hospital: 1 ☐ Inpatient 2 ☐	☐ER/Outpatient 3☐	DOA Other: 4 - Nursing	Home 5 ☐ Residence	6 Other (Spe	ocity) Os ice
27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		1
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, fac ify)	tory, office	28f. Location (Street City or Town, St		ural Route Number,
29a. Certifier (Check only one) 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owiedge, death occur ation and/or investigal	red at the time, date and placi ion, in my opinion, death occ	e, and due to the cause curred at the time, date a	e(s) and manner as and place, and due	ร รไลเฮน. e to the cause(s)
29b. Signature and title of certifier	iny Pile	1. us	29c. License number		Date signed (Mont	
30. Name in address of person who	complete value of death (III	m 23a) (Type, Print)	D25205 N. Chorles	St. Bolg	s. Md	21208

State Registrar

completely within 2 To the I

> 31. Date filed (Month Pay, Year) 32. Pristrar's Signature 2005 the Sports

12+1

24 hours after death Funeral Director:

			For State Registrar	State of Marylar		artment of H			giene 0 0	5 01099
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath	3. Time of Death
	Physici: /Medic		Michael Patr	ick Beere				January		
1	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or		ath	4c. County of	
			8810 Walther Bl		Anna b today to A	Parkvil		ro 0 D		imore
	Funeral Director		212-01-7071	7. Age (In yrs.	Yrs.	Months Days	Hours Mi		2,1920	9. Birthplace (State or Foreign Country) Maryland
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	filed within 72 hours after death with the Maryland Hygiene. Ither than "naturel", or items 23a or 28a-f show ant, the Macical Examinar must be notified at	ō	Maryland Baltimo	re F	Parkvil	le				1 ☐ Yes 2 No
	r 28a	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?
	th with		8810 Walther Bl	vd. #1205		21 234			USA	
	ems	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l.S. 13.	Was Decedent of Hi	ispanic Origin? n. Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race Black	- American Indian, , White, etc.
36	or h	by Fu	1 Never Married 2 Married	1 Yes 2 □ No		1 □ Yes 2 No	Specify:		Specify:	White
ġ	hours tural		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed		162 Dece	dent's Usual Occupa	ation		16b. Kind of Bus	in and advers
5	in 72	ojet	(Specify only highest gra	de completed)	(Give	kind of work done of DO NOT use retired	during most of w	vorking	TOD. KING OF BUS	Executive
212	y with	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Man	agement			Architec	tural Metals
פַ	be filed within 72 hours after death with the Marylan Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madreal Examinating the houlified at	Bec	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	Maiden Sumame)
<u> a</u>	should be and Mental marked o umatic eve	To	Lawrence P.	Beere			Johar	nna	Schiavo	
al	C1 (0 == 44		19a. Informant's Name/Relationship (7					Rural Route Numbe		
S,	l and lealth		Patricia Beere /					altimore,		nd 21206 City or Town, State
Baltimore, Maryland 21215-0036	Pages 1 nent of H int: If its iry or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐			sition (Name of natory or other plac				
Ħ	permit. Pages Department of Important: If ii any Injury or o		*4 □Donation 5 □Other (Specify 21. Signatu of Funer 15 rice then			Valley Me		1/19/05		, Maryland
Ba	Department of the sand of the		10.01					ral Home		D York Road son.Md.21204
			23a. Part1. Enter the disease or comp	olications that caused the dea						Approximate
l,	Pnysician		shock, or heart failure. List only		Laine	rs deme	when			Interval Between Onset and Death
	/Medical		disease or condition (resulting in death)	Due to (or as a consec		r) biche	V(1 -(
	Examiner		Sequentially list conditions	b						
	ק א	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):					
+	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consec	nuence of\:					
8760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical E			400.100 01,1					
687	ficate p phys is the	edic		. d.						
Вох	eath certifi attending for use as	n/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		75-1			23d. Date	of delivery
œ.	death	Physician/Me	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \)	1□Live birth 2□Feta 4□Pregnant at time of €		□Ectopic pregnancy □ Other (specify)			Mont	th Day Year
P.O.	that the de led by the a detached f	Phys	9 Unknown							
Ś	ires tha signed d be det	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	nderlying cause give	en in Part I.			bute to the cause of death?
0.0	w requir been si should	eted						-		3 ☐ Probably 4 ☐Unknown
Record	hast pe 2 s	Completed						24a. Was autop	pri	fere autopsy findings available for to completion of cause of eath?
a		e Co	25. Was case referred to medical					1 Tes	2 10 1	☐Yes 2☐ No
5	Physician: this certifica ral director, I	8	examiner?	Hospital: 1 Inpatient 2] ER/Outpatier	nt 3 DOA Oth	00	eath <i>(Check only o</i> Home 5 Nesic		r (Specify)
of	Attending Physician: Ir death. ector: After this certifict by the funeral director,	n: To	27. Manner of Death	28a. Date of Injury	28b. Time o	f 28c. Injun	y at		now injury occurre	
<u>io</u>	death. ctor: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1 🗆	k? Yes 2 □ No			
Division of Vital	I or Attending Phy after death. Director: After this I in by the funeral of	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, sti ify)	reet, factory, office		28f. Location (S City or Tox		r or Rural Route Number,
Ω	pital o		on Carifica 4 - Fraiting Bh	relation. To the best of multi-						
	To the Hospital or A within 24 hours after To the Funeral Direction places on the Completely filled in by	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, deat ation and/or in	n occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ccurred at the time,	cause(s) and man date and place, ar	ner as stated. nd due to the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier	10	= 52%	29c. Licens	e number	r .	29d. Date signed	(Month, Day, Year)
)			Samuel (yumo b	0	D	710	10	1/18/	01
10	2+1		30. Name and address of person who	RIO, MI) 550	5 Hopk	uns Bayvi	en Circ	le, Balti	more, M	DZIZZY
	Sta Regist		31. Date filed (MONTAP Y 0ar) 201	Registrar's Sign	ature do	nle			•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 200 /Medical 4b City, Town, or Location of Death PASADENA 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 7. Age (In yrs. last birthday) Year Social Security Number 6. Sex Funeral 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Months Days 2)5-16-646 / Usual Residence of Decedent Hours Min. 12 M 2□ F Yrs. Director the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 27 is marked other then "natural", or items 23a or 28e-f st traumatic event, the Medical Examinar must be notified 1 ☐ Yes 2 1 No **Funeral Director** 10e. Street and Number 10f. Zip Çode 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Heatth and Mentai Hygiene. ont: If item 27 Is marked other then "natural", or Items 23a or? 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married BLACK 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: by 3 Widowed 4 □ Divorced 1948 Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HASADENA, MD HOLMESPUN LOTEY/DAUGHTER DIANE ADDOALL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of himportent: If ite any injury or of once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 21. Signatury of Funda 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 Part 1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician LORONAR 10 y disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No 1 ☐ Yes Division of Vital Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only ope) Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 EP/Outpatient 3 DOA this 27. Mannal of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Watural death. 1 🗌 Yes 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

RNIE, MOZIOCI

1845 Bakurus Ro. GIEU B

ess of person who completed cause of death (Item 23a) (Type, Print)

		•	For State Registrar	State of Maryla		artment of F			liene ()5	01101
			1. Decedent's Name (First, Middle	, Last)			· · · · · ·	2. Date of Dea Month	th Day	Vane	3. Time of Death
	Physici /Medi			James Fre	ederick	Barrett		January		Year 05	1:20 P ^M
	Examir		4a. Facility Name (If not institution,	, give street and number)		4b. City, Town, o	or Location of Deat	h	4c. County of	of Death	
			510 6th Street			Laurel			Princ	e Ge	orge
	Funeral		5. Social Security Number	10/14 000	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	Year)	9. Birthpl Coun	ace (State or Foreign try)
	Director		220-70-2836 Usual Residence of Decedent	1ALM 2□F 42	Yrs.			July 19	, 1962	Puer	to Rico
	iand w		10a. State 10b. County	10c.	City, Town or Lo	ocation				10	Od. Inside City Limits
	Mary fied	to	MD Princ	e George's	Laurel						1 Yes 2 No
	deeth with the Maryland rms 23a or 28a-f show r nust be nutified at	Director	10e. Street and Number	J		10f. Zip Code			Og. Citizen of W	hat Coun	try?
	h with	O IE	510 6th Street			20	707		USA		
	deet	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H		pecify Yes or No-	14. Race	- Americ	
9	after or Its	Fu.	1 ☐ Nøver Married 2 【 Marri	ed 1 ☐ Yes 2 🕅 No		ii 1es, specily cub. 1 □ Yes 2 ☑ No		to ricari, etc.)		, White, e	
93	ral',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:					Зреспу.	Whi	te
7	"nati	Completed	15. Decedent (Specify only highes	's Education t grade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of wo	rking	16b. Kind of Bu	siness/Ind	ustry
12	withir ane. than	dmo	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		nician	(a)		Telecom		antiona
d 2	filed Hygid thar	ပို	17. Father's Name (First, Middle, I		Teci	IIIICIAII	18. Mother's Na	ne (First, Middle,			Callons
an	d be ental kad c	To Be	Wendell Jean	Barrett				a Lehman			
Maryland 21215-0036	shoul nd M mari	-	19a. Informant's Name/Relationsh		19b. Mailir	ng Address (Street			r, City or Town, S	State, Zip	Code)
Ž	nd 2 alth e 27 is r trau		Heather Brown	Barrett/Wife	510	6th Stre	et, Laur	el, MD	20707	,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Mudical Experiment must be notified at ance.		20a. Method of Disposition	200	. Place of Dispo	osition (Name of matory or other pla	ca)	Date	20c. Location - (City or To	wn, State
Ĕ	Page nent c nt: If		1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S _k	3 Chamoral Ilom State		ndel Crem	1	8/2005	Odenton	, MD	
atti	permit. Departmimports Imports any inju		21. Signature of Funeral Service I			2. Name and Addre				•	
0	8 9 E 8 8		anell	\$ (DO MO110	03 3	313 Talbo	tt Avenu	e, Laure	L, MD 2	0707	
8760, 1	are be executed / Medical / Medical Examiner Proposition Proposition	Ilcal Examiner	23a. Part1. En ar the disease, or shock, or hear failure. List disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to (or as a cons Due to (or as a cons d.	equence of):	DMA	MUI-	tifor	nC.		Interval Between Onset and Death
P.O. Box 68	death certifics e attending pl id for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F. 4 ☐ Pregnant at time o 9 ☐ Unknown	etal death 3	Ectopic pregnancy	у		23d. Date Mon		ry Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditio		resulting in the u	nderlying cause giv	ven in Part I.				e cause of death?
Vital Records,	42 00 01	Completed		p.				24a. Was a autops perform	ned? pr	ior to comeath?	sy findings available apletion of cause of
<u> </u>	ian: rtifica	BeC	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only or			
>	Physician: this certific ral director,	일	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	nt 3□ DOA Oth	ner: 4 ☐ Nursing H	lome 5 Reside	ence 6 Othe	r (Specify)
0 4	ng Pl		27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury			28d. Describe h			
sio	eath. or: A	cati	2 Accident investig	ation		M 1 🗆	Yes 2□No				
Division of	lor Att after d Diract in by	Certification;	3 Suicide 6 Could n 4 Homicide determi	ned 28e. Place of Injury - Albuilding, etc. (Spe	t home, farm, str ecify)	reet, factory, office		28f. Location (Si City or Town		r or Rural	Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funaral Director: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying (Check only one)	g Physicien: To the best of my k Examiner: On the basis of exam and manner stated.	knowledge, deatl ination and/or in	h occurred at the tir vestigation, in my o	me, date and place opinion, death occu	, and due to the c irred at the time, d	ause(s) and man ate and place, a	ner as stand due to	ated. the cause(s)
	vithin Fo th	Me	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed	(Month, E	Day, Year)
				~ MD		DOC	577	+5	1117	05	
	. 1-		30. Name and address of person v	who completed cause of death (I	tem 23a) (Tyge,			1	1 1		aurel, MD
_	10		JIII C	. Mosensta	CK, N	10 7	350 Van	Dusen Roa	ad, # 13	0,	20707
	Sta Regista		31. Date filed (Month, Day, Year) JAN 2 0 2	. Registrar's Sig	Jure 1	de					

			For State Registrar	State	of Marylan		artment of F	lealth and N Death	dental Hy	/giene	05	01102
	Physici: /Medic		1. Decedent's Name (First, Middle Berth	a	Lou	E	Battle		2. Date of D Month	Day	2005	3. Time of Death
	Examin		4a-Facility Name (If not institution, 5. Social Security Number	lealth 6. Sex	7. Age (In yrs.	•	4b. City, Town, o	If Under 24 Hrs. Hours Min.	8. Date of Bi	4c. Cour	NA 9. Birth	place (State or Foreign
	Director		219-22-9082 Usual Residence of Decedent 10a. State 10b. County	1□M 21 F	87	Yrs.			7–17	7–17		Ga.
	ie Maryla Ba-f shov diffied at	ctor	Md.	NA	100.01		imore					Y Yes 2 No
	th with th	Funeral Director	3108 Leeds Str	eet		10f. Zip Code 21229				10g. Citizen of What Country? USA		
036	urs after dea al', or Items Examinar mi	by Funer	11. Marital Status 1 Never Married 2 Marrie 3 X Widowed 4 Divorced	Armed F	2 X No ive	-	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2☐ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or N Rican, etc.)	o- 14. Pi B Spec	ace - Ameri lack, White, city: B]	
21215-0036	ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. I health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show rother traumatic svent. The Medical Examiner must be notified at	Completed by	15. Decedent (Specify only highes Elementary/Secondary (0-12) 4th grade	t grade completed) (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of work d)	king	16b. Kind of		ndustry
	ild be filed lental Hygi ked other ic svent.	To Be Co	17. Father's Name (First, Middle, L Johnnie	Last)	Jacob		itses ald	18. Mother's Nam	e (First, Middle	a, Maiden Sum		
Maryland	od 2 shou Ith and M 27 Is mar traumat		19a. Informant's Name/Relationsh Nazareth Battl		Son	19b. Maili		and Number or Rui Street, B		ber, City or Tow		
Baltimore,	Pages 1 ar nent of Hea int: If item 3 iry or other	1 10	20a. Method of Disposition 1 □ 8urial 2 □ Cremation 4 □ Donation 5 □ Other (Sc		State	emetery, crei	esition (Name of matory or other place	ce)	Date	20c. Locatio	ŕ	
Baltin	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L) one	22	Name and Addre		Balti	Baltin Imore, N Wabash	1d. 2	21215
	Physician	A	23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on	each line.			ng, such as cardiac		arrest,		Approximate Interval Between Onset and Death
. 8760,	The law requires that the death certificate be executed and be assembled by the attending physician and bage 2 should be detached for use as the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. ATHC Due to	(or as a conseq	uence of): TIC CC uence of):		PRTERY DI				io years
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ds, P	uires that signed b d be deta	by	Part II. Other significant condition Recent acute			•	, ,	ven in Part I.		tobacco use co Yes 2 □ No		the cause of death?
Der I Record	The law requir ate has been si page 2 should	Completed	ity pertension	/					perf	s an 24l opsy ormed? 2 No	o. Were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings available ompletion of cause of
Z × ×	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3□ DOA Dth	26. Place of Dear			other (Specia	(v)
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Pact Division	i ii ii	ertification;	3 Suicide 6 Could n 4 Homicide determi	not be 28e. Plac	e of Injury - At h ding, etc. (Specia		reet, factory, office			(Street and Num own, State)	nber or Rur	al Route Number,
0	To the Hospital within 24 hours a To the Funeral L corpletely filled	edical C		Examiner: On the				me, date and place, opinion, death occur				
	To the	Me	29b. Signature and title of certifier	Λ			29c. Licens			29d. Date sign		
	2		30. Name and address of person	who completed car	use of death (Iter	n 23a) (Type,	Print)	ue Baltir	-	JANUAR	y 16,	×005
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32.	Registrar's Signa	ature	ach!	ye Daltir	nore.	ir lary la	na 2	1227

		For State Registrar	State of	f Marylan	nd / Depa	artment of H	lealth ai <i>Death</i>	nd Me		ene2 () ()5	01103
		1. Decedent's Name (First, Middle, La	Decedent's Name (First, Middle, Last) 2. Date of Death									3. Time of Death
Physic		Carol Hutto Bab	bitt					J	Month	Day 14, 20	Year 05	11:15 P ^M
/Medi Examir		4a. Facility Name (If not institution, give	street and nun	nber)		4b. City, Town, or	Death		4c. County			
LAGIIII		Copper Ridge		Sykesville						Carro	11	
Funeral		5. Social Security Number 6. S		7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Min.	Date of Birth (Month, Day, eptember	Year)	9. Birthi	place (State or Foreign
Director		427-42-8178	□M 2X F	77	Yrs.	World's Days	riouis	Se	eptember	2 , 1927		sissippi
Pu ,		Usual Residence of Decedent		10a Cit	. Town or La	eating						10d. Inside City Limits
arylar show	-	10a. State 10b. County			y, Town or Lo							1 ☐ Yes 2 🔣 No
Ba-f	cto	Maryland Montgom	ery		Bethes					000		
with the	Director	10e. Street and Number				10f. Zip Code	17			g.Citizen of W nited:		•
s 23s		9202 Wadsworth D		alli e.lika n	6 42 1	2081		in 2 /C no 2*				can Indian,
laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☒ Married	Armed For 1 ☐ Yes If Yes, Giv	2∭ No e		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2凝 No	an, Mexican, Specify:	Puerto Ric	an, etc.)	Blac	k, White,	etc.
hours iural	d b	3 Widowed 4 Divorced	Year or Da	ates:	16a Dagge	dente Heuri Occur	ation		- 1 -	6b. Kind of Bu	singes/lr	odustry
15- n 72 n	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	dunna most d	of working		ob. King of bu	2111622/11	laustry
withing and the same of the sa	ם	Elementary/Secondary (0-12)	College (1	-4or 5+)		al Worker				State G	over	nment
Hygir ther		17. Father's Name (First, Middle, Last)			DOCI	ai worker		's Name (F	irst, Middle, M			
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours aft Health and Mental Hygiene. tem 27 is marked other than "natural", or other fraumatic event, the Medical Exem	To Be	Hampton Hutto							ellan			
lar and ls m		19a. Informant's Name/Relationship (ng Address (Street				-		
and and ealth m 27		Albert Babbitt /H	usband	1001.0	_	Wadsworth	Drive					
Ore of H or Heir		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from 5		lace of Dispo cemetery, crei	sition (Name of matory or other plac	;e) Ja	nuary	7 19,	0c, Location -		
altimore, mit. Pages 1 ar partment of Hea portant: If Item 3 y injury or other		' 4 ☐ Donation 5 ☐ Other (Specifi		Gat	te of He	aven Cemete	ery	2005	S	ilver Spi	ring,	Maryland
Baltimore, IV permit. Pages 1 and Department of Health Important: If Item 27 any injury or other troops.		21. Signature of Fuperal Service Lices	ee	M013	53 Ro	R Name and Addre bert A. Pui 57 Wisconsi	ss of Facility mphrey In Avenu	Funera e, Bet	1 Home/E hesda, M	ethesda- aryl <i>a</i> nd	Chevy 2081	Chase, Inc.
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that co	aused the deat	h. Do not ent	er the mode of dyin	ng, such as c	ardiac or re	espiratory arre	st,		Approximate Interval Between
Physician	0.0	Immediate Cause (Final disease or condition	/	0-0	Line							Onset and Death
/Medical		resulting in death)	a. Due to (or as a conseq	uence of):						\neg	1800
Examiner			b									
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ing pt	Med	IF FEMALE:										
BOX 6 leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?		inth 2 ☐ Feta	ideath 3□	Ectopic pregnancy	,			23d. Date Mor		ery Day Year
at the desiby the all	sici	1 ☐ Yes 2 ☐ Mò 9 ☐ Unknown	4⊟Pregn: 9⊟Unkno	ant at time of down	leath 5□	Other (specify)						
D at the d by the etache	Phy	Part II. Other significant conditions of			ultina in the co	- deskip - ee	on in Part I		23a Did tob	acco use contr	ibute to t	he cause of death?
Hecords, P. The law requires that all has been signed b	ρ	Part II. Other significant conditions of	oritributing to de	ALII DULIIOLI 165	aiting in the ai	ilderlying cause giv	on in ranti.		1 ☐ Yes	__		pably 4 □Unknown
ecords, law requires t as been signe	eted							_				
lec law has b	nple								24a. Was an autopsy perform	P	vere auto rior to co eath?	opsy findings available impletion of cause of
	Completed									No 1	Yes	2 □ No
If VITAL REC nysician: The law nis certificate has to director, page 2 s	Be	25. Was case referred to medical examiner?	Moneitak			0#	00		Check only one			
OT Physic ruthis of real directions of the physical directions of the physi	ဥ	1 ☐ Yes 2 No			ER/Outpatien		4 Nurs		5 Resider			(y)
ding F h. After funer	no	27. Manner of Death Statural 5 Pending		h, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2.∐N		d. Describe how	v injury occurre	iu.	
SIC Itend Itend Iten Iten	cat	2 Accident investigation 3 Suicide 6 Could not be		of laiun. At h			163 2 110		Location (Str	et and Numbe	er or Run	al Route Number,
DIVISION I or Attending efter death. Director: Afte	Certification:	4 ☐ Homicide determined	buildir	ng, etc. (Specify	y)	eet, factory, office		201	City or Town,	State)	7 07 7 1070	ar riouto vambor,
pital ours oral filled		29a. Certifying Ph	vsician: To the	best of my kno	wledge death	occurred at the time	ne, date and	l place, and	d due to the ca	use(s) and mar	ner as s	tated.
24 h	Medical			sis of examina		vestigation, in my o						
UNISION OT VITA To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely filled in by the funeral director.	Me	29b. Signature and title of certifier				29c. Licens	e number		29	d. Date signed	(Month,	Day, Year)
⊢ <i>s</i> ⊢ ō		17111	1//	M.	0	0	nee	17-	,	1/17	Inc	
_		30. Name and address of person who	ompleted cause	e of death (Item	n 23a) (Type.	Print)	110	15.		1/1/	100	
9		Wilbur Kas	295	Ston	er K	Tro St	307	1.12	st	ast.	111	0 21157
Sta	ate	31. Date filed (Month, Day, Year)	32. P	gistrar's Signa	iture	1 4	- /			No.		
Regist		1641 0 0	nor E		H A	acade)						

Wilson Curtis

Baltimore, Maryland 21215-0036

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		For State		Department of Health and I	Mental Hygien	2005 01104
		Registrar 1. Decedent's Name (First, Middle, Las		Certificate of Death	Reg. N	3. Time of Death
Physicia		Wilson	Curtis			15. 2005 11:45AM
/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death		c. County of Death
		5. Social Security Number 6. S	ex 7. Age (in yrs. last bir	thday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
Funeral Director	1		Set u a m c Let =	Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9 Manual 2
and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tow	n or Location	1000	10d. Inside City Limits
Marylan -f show fled at	tor	MD	Pal.	timore,		1 Yes 2 □ No
ith the M or 28a-f)irec	10e. Street and Number	100	10f. Zip Code	10g. C	Citizen of What Country?
th w	Funeral Director	807 Brach	12. Was Decedent Ever in U.S.	21212	Consider Van or No	14. Race - American Indian,
after dea or Items	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1€ZYes 2 □ No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.)	Black, White, etc.
72 hours a "natural", c	d by	3 Widowed 4 □ Divorced	Yes, Give Year or Dates:	1 ☐ Yes 2 XNo Specify:		Specify: Black
in 72 t	Completed	15. Decedent's Ec (Specify only highest gra	de completed)	. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king 16b.	Kind of Business/Industry
od with giene.	Som	Elementary/Secondary (0-12)	College (1-4or 5+)	echanical Eng	ineep	Handicas
be file stal Hy of oth	Be	17. Father's Name (First, Middle, Last)	. 1	18. Mother's Nar	ne (First, Middle, Maide	en Sumame)
nd 2 should be filed within alth and Mental Hygiene. 27 Is marked other than in traumatic event, Ira Ma	ဥ	19a, Informant's Name/Relationship	Type. Print) 19b	. Mailing Address (Street and Number or Ru	ral Route Number, City	or Town, State, Zip Code)
s 1 and 2 should be filed within 72 ho f Health and Mental Hygiene. Item 27 Is marked other than "natur other traumatic event, the Medical		Terry Custi	3 (SON) 5:	500 Tranhoe A	we Bal	to.MD 21212
permit. Pages 1 a Department of Hes Important: If item any Injury or othe		20a. Method of Disposition 1 X Burial 2 Cremation 3 C	comoto	f Disposition (Name of ry, crematory or other place)	Date 20c. I	Location - City or Town, State
permit. Pages Department of Important: If if any Injury or once.		 4 □ Donation 5 □ Other (Specify 21. Signatury of Funeral Service Licen 	, van	(awn (emeter) 1/2	1/05 Ba	Himore, MD
permit. Departr Importr any Inji		150 6	1+0	Vaugher Corecus	d Ruseral	MD 21212
		23a. Part1. Enter the disease, or com- shock, or fleart failure. List only	plications that caused the death. Do none cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Pnysician		Immediate Cause (Final disease or condition resulting in death)	a congestive	Heart Failur	2	Onset and Death
/Medical Examiner		1500ming in County	Due to (3) as a consequence	or): OVILLATION		
n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	of):		
be executed cian and ourial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. CIVVN099 0	4 Liver		
a be ex sician s buria			d	· · · · · · · · · · · · · · · · · · ·		
eath certificate be attending physici for use as the bu	Medic	PECEMALE.				
ath ce	lan/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death			23d. Date of delivery Month Day Year
that the de led by the a	Physician/Medical	1 Yes 2 No 9 Unknown	4⊞Pregnant at time of death 9⊞Unknown	5 Other (specify)		
2 2 2 2	by PI	Part II. Other significant conditions of	ontributing to death but not resulting in		23e. Did tobacco	use contribute to the cause of death?
w require been si	eted	649TV01V1709	TIMA BIECA,	Sacral	1 ☐ Yes	2 No 3 Probably 4 ∰Unknown
ne law s has t ge 2 s	Completed	DECUBITUS	Ulcers		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
	0	25. Was case referred to medical		26. Place of Dea	th (Check only one)	lo 1 Yes 2 No
hysici his cei	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 □ ER/Ou		ome 5 Residence	
ding Ph.	tion:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Time of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred
Attan or deat actor: by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e 28e. Place of Injury - At home, fa		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number,
Ital or ral Dir		* Nomicide	building, etc. (Specify)		City or Town, Sta	(8)
To the Hospital or Attanding Physician: within 24 hours alter death. To the Funeral Director: After this certifics completely filled in by the funeral director, to	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my knowledge niner: On the basis of examination an and manner stated.	e, death occurred at the time, date and place ad/or investigation, in my opinion, death occu	, and due to the cause(rred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier	4. Kalisuni	29c. License number	29d. D	ate signed (Month, Day, Year)
		•	M	p Res000		Tanuary 17,2005
10		30. Name and address of person who Michel Katvo	uni 5601 6	(Type, Print) Ch Raven Blvd	Baltin	Tanvary 17,2005
Sta Registr		31. Date filed (Month, Day, Year) JAN 2 0 2005	2. Registrar's Signature	porte		

Ernest Cherry 05-00252 dl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11	1	For State Registrar	State of Maryland / Dep	partment of Health and Nertificate of Death	Mental Hygie	6000	01105		
Physicia	n	1. Decedent's Name (First, Middle, Last)	St CHERRY		2. Date of Death Month January 1	Day Year	3. Time of Death 6:18 P		
/Medica Examine		4a. Facility Name (If not institution, give s 1328 Winston Ave		4b. City, Town, or Location of Death Baltimore	-	4c. County of Death	0.10 1		
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday M 2□F 744 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	130 NORTH	ace (State or Foreign try) CAROUNA		
aryjand show det		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	Location		10	0d. Inside City Limits		
death with the Maryland me 23a or 28e-f show roast be notified at	Funeral Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Coun			
er death v Iteme 23s	uneral	./		3. Was Decedent of Hispanic Origin? (Si If Yes, specify Cyban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, o			
urs a	<u>م</u>	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ	1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	16	Specify: BL	ACK dustry		
within 72 iene.	Completed	(Specify only highest grade	e completed) (Giv	ve kind of work done during most of wor . DO NOT use retired) DOMESHC	king	DRIVAT	•		
land lid be fil hental H rked oth tic even	To Be C	17. Father's Name (First, Middle, Last) William	CHERRY	18. Mother's Nan	ne (First, Middle, Ma KTHA	iden Sumame) EVANS			
y, Maryla and 2 should ealth and Men n 27 is marke ier treumatic		19a. Informant's Name/Relationship (Ty,) ALICE M. CHER	pe, Print) WIFE 132	illing Address (Street an Number or Ru WINSON A	IF. SHIT	ity or Town, State, Zip MD 2	^{Code)} 1239		
or the roth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	cometent co	position (Name of rematory or other place) CEMETERY		oc. Location - City or To			
Baltimo		21. Signature of Funeral Service Licens	Green	CENETERY 22. Name and Address of Facility VA 4905 YORK ROAD	BACTIMON		FUNERAL AM.		
Pnysician		shock, or heart failure. List only or Immediate Cause (Final	ications that caused the death. Do not ene cause on each line.	enter the mode of dying, such as cardiac			Approximate Interval Between Onset and Death		
/Medical Examiner		disease or condition resulting in death)			100 101				
o d ansit	Examiner	Se_uentialy list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):						
8760, cate be executed by sician and the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a consequence of):						
OX 6	an/Medi	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	3 □Ectopic pregnancy		23d. Date of delive	*		
P.O. B that the deatl ed by the atte	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		5 Other (specify)		Month	Day Year		
cords, F w requires tha been signed should be de		Part II. Other significant conditions col	ntributing to death but not resulting in the		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
II Record The law requir ate has been si page 2 should	Completed				24a. Was an autopsy performe	prior to co	psy findings available impletion of cause of 2 No		
	Be	25. Was case referred to medical examiner?	Hospital:	The state of the s	ath (Check only one)				
on of ding Phys	tion: To	27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at		5 ☐ Residence 6 ☑ Other (Specify) SCENE d. Describe how injury occurred			
Division of a or Attending Phy after death. Director: After this din by the funeral d	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,		
Division To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medicai C		rsician: To the best of my knowledge, de iner: On the basis of examination and/or and manner stated.						
To the within To the compl	Me	29b. Signature and title of certifier	~ 011	29c. License number	290	d. Date signed (Month,	Day, Year)		
		MICHA	YIV	OCME	Ja	anuary 11,	2005		
10		30. Name and address of person who c	omplified cause of death (Item 23a) (Typ	90, Print) 111 Penn Street I	Baltimore.	Marvland	21201		
Sta Registi		31. Date filed (Month, Day, Year) JAN 2 0 2005	2. Registrar's Signature	de					

		1 - For State Registrar	State of Marylan		artme		ealth and		giene Reg. No	005	01106	
Physi /Med	lical	Decedent's Name (First, Middle, Last) Ludelia Aa. Facility Name (If not institution, give seconds)	Cr	awford	4h Cii	v Tourn or	Location of Dea	2. Date of De Month Januar	р Дау у 7,	y Year 2005 County of Death	3. Time of Death 5:36 A	
Exam	- Sr	18355 Lost Knife 5. Social Security Number 6. Sex	Circle	last hirthday)	Mon		ry Vill	age	M	lontgomer		
. Funera Directo			м 2\sqr		Month		Hours Mir		24,	1907	intry) MS	
17215-U036 within 72 hours after death with the Maryland ene than "netural; or tems 23s or 28s-f show than "netural Executarity in the formulation"	ector	10a. State 10b. County 10c. City, Town or Location								tizen of What Cou	10d. Inside City Limits 1 □ Yes 2 □ No	
ath with 23s or	ral Dir	18355 Lost Knife	Circle		101.2	2088	6			USA		
Baltimore, Maryland 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23s or 28a-f show any injury or other treumatic event, the Market Examiliar milited at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2√2 No		3. Was Decedent of Hispanic Origin? (Specify Yes o If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 ☐ XNo Specify:			Specify Yes or No into Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black		, etc.	
21215-0036 od within 72 hours aff gjiene. er than "netural", or in the Man Extent	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	de completed) (Give life. L			dent's Usual Occupation kind of work done during most of working DO NOT use retired)			16b. Kind of Business/Industry			
land 2 lid be filed v fental Hygie rked other t	To Be Co	5 17. Father's Name (First, Middle, Last) Rufus Nichols		Home				me (First, Middle, Maide tia Lofton		wn Home en Surname)		
Maryiand nd 2 should be file alth and Mental Hy 27 Is marked oth	-	19a. Informant's Name/Relationship (Ty, Bobbie Burton - De		1				Rural Route Numb		or Town, State, Zij	p Code)	
Baitimore, permit. Pages 1 at Department of Hea Important: If item	1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R *4 ☐ Donation 5 ☐ Other (Specify)	ternoval nom State	Place of Disponentery, creater Linc				Date 13/2005		ocation - City or T		
permit. Popartm Departm Importar any injui	N N N N N N N N N N N N N N N N N N N	21. Signature of Funeral Service License	99	22	2. Name	and Addres	s of Facility	Fort Lin	coln	Funeral	Home	
Cate be executed Cate by Examine Physician and Physician and Physician and Street Physician a	icai Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influry that initiated events resulting in death) Last Approximate Interval Between Onset and Death Disease or influry pertension Due to (or as a consequence of): Anema d. Anema										
SOX to ath certification or use as	Physician/Med									23d. Date of delivery Month Day Year		
S, T es that igned b	b									cco use contribute to the cause of death? 2Ⅺ No 3☐ Probably 4 ☐ Unknown		
AI HECOTOS, The law requires reate has been sign page 2 should be	Completed							1 ☐ Yes	psy ormed? 2 X No	prior to co death?	opsy findings available ompletion of cause of	
VISION OF VITAL IN Attending Physicien: The death. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼No 27. Manner of Death 1 ▼Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury					Home 5 ₹ Resi			fy)	
in State	Certification:	3 Suicide 6 Could not be 4 Homicide determined						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
DIVI To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination)	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death	n occurre vestigation	d at the tim	e, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) date and) and manner as s d place, and due to	stated. o the cause(s)	
To th within To th	Me	29b. Signature and title of certifier		29c. License number D41102MD					te signed (Month, 11/2005	Day, Year)		
	tate	30. Name and address of person who con Dr. Vini Ganti 31. Date filed (Month Day, Year)	ompleted cause of death (Iter 19529 Docto	r's Dr		erman	town MD	20874				
Regis		31. Date filed (Month, Day, Year) JAN 2 0 201	05		-							

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		1	For State Registrar		Sta	te of Ma	aryland		artment of H tificate of L			giene2 () ()5	011	07
	Division in the	V.	1. Decedent's Name	(First, Middle, I	Last)						2. Date of De Month	ath Day	Year	3. Time of	
П	Physicia /Medic	al -	ALDA	VICTOR		CAUD	ILL				01		05	3:30	О А м
	Examin	er	4a. Facility Name (If I	_					4b. City, Town, or		h	4c. County o			
			MARINER 5. Social Security Nu		OF FC			ast birthday)	FOREST If Under 1 Year	HLLL If Under 24 Hrs	8. Date of Bir	HARI		lace (State o	r Foreign
	Funeral Director		220-30-59		1 □ M 2	Ž√F	86		Months Days	Hours Min	Sept. 1	2, Year) 2, 1918	Nor	iace (State o try) th Car	colina
	pu 🔉		Usual Residence of 0	Decedent 10b. County			10c. City.	. Town or Lo	cation				1	0d. Inside Ci	ty Limits
	Maryla f sho	ō	Maryland	Baltim	ore			ltimor						1 🗌 Yes	2 XNo
	r 28a-	rect	10e. Street and Num		DIC		<u>Da</u>	LCHINOL	10f. Zip Code			10g. Citizen of W	hat Cour	itry?	
	th with	al D	9878 Bird	River	Road				21220)		USA			
	r dea	Funeral Director	11. Marital Status		Arn	s Decedent ned Forces?	?	S. 13.	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (in, Mexican, Pue	Specify Yes or No to Rican, etc.)	14. Race Black	- Americ c, White,	an Indian, etc.	
36	within 72 hours after death with the Maryland ene. Then "neturel", or tlems 23a or 28a-f show the Modic Examiner mat be notified a	by Fi	1 ☐ Never Marrie 3 ☑ Widowed 4	_	lf Y	Yes 2X es, Give ar or Dates:	No		1 ☐ Yes 2 X No	Specify:		Specify:	T/v	hite	
Ş	2 hou	ted t	2.5	15. Decedent's	Education			16a. Dece	dent's Usual Occup	ation	orkina	16b. Kind of Bu			
21215-0036	thin 7 Ie.	Completed	Elementary/Secon	fy only highest dary (0-12)		llege (1-4or	5+)	life.	DO NOT use retired	1)	in Kill g			<i>.</i>	
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Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Branitri filem 27 is marked other than "neturely or Items 23a or 28a-f show any injury or other treumatic event, Ite Modified at any injury or other treumatic event, Ite Modified.	o Be	Jesse	Barnet		Osbo	rne			Margie	Mae	John			
ary	shoul nd Me mark umati	은	19a. Informant's Nar	me/Relationship	о (Турө, Pri			19b. Maili	ng Address (Street		ural Route Numb	er, City or Town,	State, Zip	Code)	1.5
Ž	and 2		Billy Cau	dill -	Son				Norrisvi						.61
ore	of He of He if Item or oth		20a. Method of Disposition 2 Burial 2 D	osition		al from State			sition (Name of matory or other plac		Date	20c. Location -			
Baltimore,	t. Pag tment tent:		` 4 □ Donation	5 ∐ Other (Spe	cify)	-	Osbo		lem. Bapt:		20/05	Sparta, Funeral			
Bal	permi Depa Impo any ir		21. Signature of Fun	en Plan	Vo sons	/,			.317 Cokes						
M			23a. Part1. Enter th	e disease, or c	omplication:	s that cause	d the death							Approximat Interval Bet	e
	Physician [*]		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pressure Corona and Death								Death				
	/Medical		resulting in death) Due to (or as a consequence of):						0	7	· · ·				
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Вох	death certific e attending pl d for use as t	cian/	23b. Was decedent in the past 12 i	months?	10	Live birth Pregnant a	2 Fetal	death 3	☐Ectopic pregnancy ☐ Other (specify)	/		23d. Date Mor			Year
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Vital	Physicien: this certific ral director,	o Be	25. Was case referrexaminer?		Hospita	al: 1 🗆 Inpati	ient 2 🗆	ER/Outpatie	nt 3 DOA Oth		eath (Check only Home 5 \subsetence Res	one) idence 6 □Othe	er (Specii	(v)	
ot		1	27. Manner of Death	1	288	a. Date of Inj	ury	28b. Time o				how injury occurr		,	
ior	Attending F r death. sctor: After by the funer	atio	2 Accident Investigation M 1 Yes 2 No												
Division	after death after death Director:	Certification;	3 Suicide 4 Homicide	6 Could no determin			njury - At ho etc. <i>(Specif</i> y		reet, factory, office		28f. Location City or To	(Street and Numb wn, State)	er or Run	al Route Num	iber,
	Hospitel		29a, Certifier	1 Certifying	Physician	: To the bes	t of my kno	wledge, dea	th occurred at the tir	me, date and pia	e, and due to the	cause(s) and ma	nner as s	tated.	
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	edical			xaminer: C		of examinat		nvestigation, in my o						5)
	To th withir To th comp	Me	29b. Signature and	title of certifier					29c. Licens	se number		29d. Date signed	d (Month,	Day, Year)	
)			Da	1-2/5	Dr				53	2 2 75		JANUR	1-117	, 200	1
	1		30. Name and addre	יאוות חדו	v 61°				, Print) AD, BEL A	IR. MD	21014		*		
	St	ate	31. Date filed (Mon	b Day, Year)	., 010	32. g iš	trar's Signa	iture		,					·
	Regist	rar	J.	MIY Z U	2005	De	w)	K A	beeter						

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ORIGINAL

	1	State of Maryland / Department of 1- State Registrar Certificate of		ental Hygier	211115 DIIOR					
Physicia	n	1. Decedent's Name (First, Middle, Last) Florence Ollvia L. Cox		2. Date of Death	Day Year 3. Time of Death					
/Medica Examine	r '	4a. Facility Name (If not institution, give street and number) 2625 Ceci/ Avenue 4b. City, Town,	or Location of Death		4c. County of Death					
Funeral Director		5. Social Security Number CONTROL OF SOCIAL SECURITY NUMBER SECURITY	r If Under 24 Hrs. s Hours Min.	8. Date of Birth (Month, Day, Yea September 9	9. Birthplace (State or Foreign Country) 1929 VA					
e Maryland le-f ehow	ctor	10a. State 10b. County 10c. City, Town or Location MD N/A Baltimore			10d. Inside City Limits 1 → es 2 □ No					
ter death with the Marylar iteme 23s or 28e-1 show instrumet be nutified at	raiDi		1218		Citizen of What Country?					
D36	2	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Nidowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 D No If Yes, Give	Hispanic Origin? (Speban, Mexican, Puerto For Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: 13 lack					
21215-0036 bd within 72 hours afl gliene. er than "natural", or if the Medical Exerti	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	e during most of workir ed)	ng	Kind of Business/Industry					
	Be	17. Father's Name (First, Middle, Last) Jeff Davis		(First, Middle, Maid						
Mary d 2 shouth and h th and h 7 is man treumai	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street	at and Number or Rura		y or Town, State, Zip Code) 5 Balfimune MD 21213					
Baltimore, permit. Pages 1 an Department of Heal mportant: If Item 2 any injury or other 2006.	-	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other pl	ace) 7/18	ate 20c.	Location - City or Town, Slate Roll Hanne MD					
Baltim permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licensee 22. Name and Addi Hari 5/26	ress Facility P. Close Belate	Funeral Road, B	Service, P. A q Himono MDZ1206					
Physician /Medical Examiner		23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	ing, sacri as caraiac or	respiratory arrest,	Interval Petwoon					
760,	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):	Due to (or as a consequence of):							
Box 687 death certificate e attending phy of for use as the	Physician/Medical	d	су	-	23d. Date of delivery Month Day Year					
	ò	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	outing to death but not resulting in the underlying cause given in Part I.							
	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?					
of Vital F Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)							
ding h. After fune	tion; To	27. Manner of Death 1 ★Natural 5 Pending (Month, Day Year) 1 ★Natural 5 Pending (Month, Day Year)	4 Natising Hon	ne 5 A Residence 8d. Describe how in						
Division Itel or Attending Its after death. rei Director: Afte led in by the fune	Certification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · Al home, farm, street, factory, office building, etc. (Specify)	2	8f. Location (Street City or Town, St	and Number or Rural Route Number, ate)					
Divisi To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Medicai	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurred at the 2 Medical Exeminer: On the basis of examination and/or investigation, in my and manner slated. 29b. Signature and tille of publier 29c. Licer	time, date and place, a opinion, death occurre	ed at the time, date a	v(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)					
T viii		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUMAN RAO 3333 N. CALVERY	577t3	1/	119/05					
4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUM AN 2 3333 N CALVERY 31. Date filed (Month, Day, Year) 32. Reflector's Signature	ST BALT	· IMORE	MD 2/2/8					
Stat Registra		31. Date filed (Month, Day Year) JAN 2 0 2005 32. Refistrar's Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 4. VASHTI COATES JANUARY 2005 10:50a /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner GLADYS SPELLMAN SPECIALTY HOSPITAL HYATTSVILLE PRINCE GEORGE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Director 88 219-16-0892 8-20-1916 MARYLAND Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, Ite Mov cal Examinar must be notified at 1 Yes 2 □ No MD. ANNE ARUNDEL LOTHIAN Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 61 ARK RD. 20711 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: δ If Yes, Give Year or Dates: Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) -0-LAUNDRY US NAVAL ACADEMY it of Health and Mental Hygis If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN H. THOMAS MARY M. BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTHA ROBINSON (DAUGHTER) 5431 BASS PLACE S.E. WASHINGTON, DC 20019 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If Ite any injury or ot once. 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ZION U.M. CHURCH CEM. 1-10-2005 LOTHIAN, MARYLAND MT. 21. Signature of Funeral Service Licensee LARRY G. REESE 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. Zanny S. Reese Moo 483 821 WEST ST. ANNAPOLIS, MARY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 WEST ST. ANNAPOLIS, MARYLAND 21401 Immediate Cause (Final disease or condition resulting in death) Physician SEIZURE DISORDER /Medical Due to (or as a consequence of) Examiner ANOXIC ENCEPHALOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-transit CARDIAC ARREST Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician by Physician/Medicai IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the funeral director, page 2 should be detached 9 Unknown 9 Unknown has been signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RESPIRATORY FAILURE/VENTILATOR DEPENDANT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 € No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient Certification: To 1 ☐ Yes 2 ₹ No 3 DOA After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the within 24 hours efter deal To the Funeral Director: 6 Could not be determined 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) D0026024 JANUARY 4, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LESTER MILES, MD 6490 LANDOVER RD, LANDOVER, MARYLAND 20785 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 6:45 AM 2005 JOHN E. DALTON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BURNIE ARUNDEL GLEN NORTH ARUNDEL HOSTITAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F XX Days Months Director MD 216,20,7536 FEB 6. Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. Inside City Limits 10a State 27 ia marked other than "natural", or Hema 23a or 28a-f show traumatic event, the Medical Examinar roast by notified at 1 ☐ Yes 2 ☐ No Director MD ANNE ARUNDEL GLEN BURNIE $\bar{x}\bar{x}$ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 721 SEAGROVE RD 21060 Completed by Funeral **IISA** ould be filed within 72 hours after death Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. YYes 2 No 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify: Specify: 3 ₩idowed 4 □ Divorced Year or Dates: KOREA WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER **FACTORY** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk MARGARET DALTON ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if item 27 is any injury or other traignes. RD. BALTIMORE, MD 21211 DOLORES HUBBARD SISTER 3911 KESWICK 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State r place) 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) LOUDON PARK CEM. 1.19.2005 BALTIMORE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility FINK FUNERAL HOME, P.A. GREGORY FINK M01148 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final Physician DOXEM disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ronic Obstructive Pulmonary Disease use as the burial-transit that initiated events resulting in death) Last the attending physician Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy No. Division of Vital Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2X No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes this D te of Injury (Month, Day Year) 28c. Injury at Work? 27. Manper of eath 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending death. € ☐ Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0032144 -15-2005 completed cause of death (Item 23a) (Type, Pri glen Burnic MD 21061

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		•	For State Registrar	State of M	1 arylan		artment of h		and Mental F	lygien Reg. N	/ 11 11 1	5 01111
	Physicia	an	1. Decedent's Name (First, Midd.						2. Date of Month	D	ay Year	
	/Medic	al	4a. Facility Name (If not institutio	Doyle Wi		Dick	4b. City, Town, o	or Location o	Janua of Death		5, 2005 c. County of De	
	Examin	er	4203 Forsynthi		,		Pasader				nne Arı	
	Funeral		5. Social Security Number			ast birthday)	If Under 1 Year Months Days	If Under a	Min. (Month,	Dav. Year		irthplace (State or Foreign
	Director		224-16-7444 Usual Residence of Decedent	XX	86	Yrs.			June .	11, 1	918 Ma	ryland
	yland		10a. State 10b. County	1	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Ba-fs	ctor		Arundel	Pas	adena						1 Yes 2 No
	with the	Dire	10e. Street and Number 4203 Forsythia	Lane			10f. Zip Code 2112	2			itizen of What (Country?
	ms 23	nerai	11. Marital Status	12. Was Deceden	t Ever in U.	S. 13.			gin? (Specify Yes or , Puerto Rican, etc.)		14. Race - An	
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other traumatic event, I've Medical Evantret must be notified at once.	Completed by Funeral Director	1 Never Married 2 Mar	If Yes Give	JNo 194	2	1 Tes, specily Cub 1 ☐ Yes 2 🖾 No		, ruello nicali, etc.)		Black, Wh Specify: W	· ·
21215-0036	tural,	ed b	3 Widowed 4 Divorced	Year or Dates	: -194	16a, Dece	dent's Usual Occup	pation		16b.	Kind of Busines	s/Industry
215	hin 72 an "na Medic	plet		est grade completed) College (1-40)	r 5+)	(Give	kind of work done DO NOT use retire	during most	of working			,
7	ygiene ygiene ner tha		Grade 7			Shee	et Metal	· · · · · · · · · · · · · · · · · · ·		_	elf-Emp	loyed
and	t be fill ntal H ed ott) Be	17. Father's Name (First, Middle, Doyle Peter Die						r's Name <i>(First, Mid</i> ietta You:		n Sumame)	•
Ž	should nd Me mark mark	ို	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street	1	r or Rural Route Nu		or Town, State	Zip Code)
Ž,	s 1 and 2 at the alth although the structure s		Doris Dick /	spouse			Forsythi	a Lan		_	aryland	
Baltimore, Maryland	ges 1 of He If item		20a. Method of Disposition 1XXBurial 2 ☐ Cremation	3 □Removal from Stat	e c	emetery, cier	sition (Name of matory or other pla		Date		ocation - City o	
<u>ti</u>	it. Pagintment intant: njury		* 4 □ Donation 5 □ Other (\$ 21. Signature) of Funeral Service	A	F't.				1/19/2005	_	entwood	, MD
Ba	Depa Impo any ii			and dead	M00160				ral Home, enue Laui		Marylan	d 20707
	*		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final	t only one cause on each	line.		er the mode of dyi	ng, such as	cardiac or respirator	y arrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Brain Due to (or a								1 month
į,	Examiner		Sequentially list conditions,	b								
7	led isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Figure 1)	Due to (or a	is a consequ	ience of):						
C.	execuin and ial-trai	Examine	that initiated events resulting in death) Last	c. Due to (or a	is a consequ	uence of):			,			
8760,	cate be executed oblysician and the burial-transit	ical		d								
Ó	aath certifici attending pl for use as t	Physician/Med	IF FEMALE:	23c. If yes, outcom	ne of pregna	ncy					23d. Date of d	elivery
Box.		ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant	2 Fetal at time of de	death 3	Ectopic pregnanc Other (specify) _	у		_	Month	Day Year
<u>O</u>		hys	9 🗆 Unknown	9∐ Unknown								
Records, I	sign sign d be	by	Part II. Other significant conditi	ions contributing to death	but not resu	ulting in the u	nderlying cause gr	ven in Part I.		d tobacco ☐ Yes 2		to the cause of death? Probably 4 XIMnknown
eco	as b	Completed				<u>-</u>			24a. W	itopsy	prior to	autopsy findings available ocompletion of cause of
	th ate pag	Соп							1 ☐ Ye	rformed? s 2XX	death?	
Vital	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 X X lo	Hospital:	tions O	ER/Outpatier	- 2C DOA O	hor	of Death (Check on		e Clother (Se	angifu)
of	g Phys er this eral di	F :	27. Manner of Death	28a. Date of In		28b. Time of Injury	f 28c. Inju		28d. Descrit			ecny)
sion	Attending F r death. sctor: After by the funer	atio	E / toolgon	igation	ray . oar,	пдыту		Yes 2 1				
Division	l or Attendater deatl Director:	ertification	3 Suicide 6 Could 4 Homicide determ	minord 200. Place of I	njury - At ho etc. <i>(Specif</i>)	me, farm, str	eet, factory, office			n (Street a Town, Sta		Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	dical C		ng Physician: To the best Examiner: On the basis and manner:	of examinal							
	To the I within 2 To the I complet	Med	29b. Signature and little of certific			1	29c. Licens	-			ate signed (Mor	
	- > = 0		Then	ell A	de	<u> </u>	0//	315	5)	Ja	nua	117,2005
	10+1		30 Name and address of person	who completed cause of	death (Item	23a) (Type,	Print)	111	Por R/	R.	M	17,2005 1. 2005
	Sta	te	31. Date filed (Month, Day, Year	207 h	strar's Signa	ture	105/10-		JWE UTE	מערי	7/4	, con
	Registr	ar	JAN 2 0	2005 Bear	~ 1	A	42/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 Reg. No. U Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 2311 nevesa Lunn 2005 MAUMAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** NIA HEALTHCAVE sactimore IGNES IMIAC If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🗹 F MD 24-54-4551 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-f show ral', or Itams 23a or 28e-f shov MD 1 XYes 2 □ No Baltimore Completed by Funeral Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 and of Healih and Mental Hygiene.
ant: If item 27 is marked other then "natural; or Items 23a or: ury or other traumatic event. The Madical Examinator relatives. 793 Grantley Street 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify: Yas, Giva Specify: DIACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Social Secunta Elementary/Secondary (0-12) College (1-4or 5+) Center Administration ZVERIS 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) LLN K-Baltimore, Maryland 17. Fathers Name (First, Middle, Last) Be Conteaus Harold 2 19a. Informant's Name/Relations p 2ype, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 793 Grantley Street Baltimore MD 21229 L. Epps/Husband Wendell 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or KING MEMDRIAL 01.21.05 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C. Greek Funeval Services 5 SI Baltinger Nagronal Pile Baltimore MD 21229 21. Signature of Funday Service Licent 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erstic Valcular Disease Pnysician Atherosch ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical Examiner the burial-transit resulting in death) Last The law requires that the death certificate be exec Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe be c Completed by 1 Yes 2 No 3 Probably 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 → No page 2 1 Yes of Vital 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only or Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2□No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attanding 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Accident Director 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a
To tha Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number to, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Caton Denue Baltimore Esposito Susan 32 Pegistrar's Signature 31. Date filed (Mond Ney 2

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month - 18 - 2005 10:05 AM **FILIOTT** ALBIA R. 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE RUXTON CARE RUXTON MANOR If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months MARYLAND 1 M 2XXF 88 Yrs. 06-06-1916 216-20-4119 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Tyes XX No **FALLSTON** HARFORD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U. S. A. 21047 ROAD 2310 BALDWIN MILL 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XXVo If Yes, Give Year or Dates: WHITE 1 ☐ Never Married 2 ☐ Married Specify: 3XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) BALTIMORE COUNTY College (1-4or 5+) **TEACHER** Elementary/Secondary (0-12) DEPARTMENT OF EDUCATION PLUS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RICHARDSON NORA RIGGIN WILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2310 BALDWIN MILL ROAD, FALLSTON, MARYLAND, 21047 (DAUGHTER) PAMELA E. HOOPER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition JAN 21 2005 TIMONIUM, MARYLAND MBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) DULANEY VALLEY M. GARDENS 1050 YORK ROAD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee RUCK TOWSON FUNERAL HOME, INC TOWSON, MD. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death a Athensclennic Cardiovascular Divease Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 45 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

Physician /Medical **Examiner**

Physician

/Medical

Examiner

MD.

Funeral

Director

r than "natural", or Items 23s or 28s-f show the Medical Exercities must be notified at

Pagas 1 and 2 should be filad within 72 hours after daath with

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Baltimore, Maryland 21215-0020

Funeral Director

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Physician/Medical ģ Be Completed

Examine

cata has bean signed by the attanding physician and page 2 should be datached for usa as the bunal-transit Attending Physician: The law raquiras that the daath certificata be axecuted Certification: To this funeral After ō

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Division of Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No TL Yes Z M NU 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending 1 Natural 2 🗌 No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated The Centifying Physician. To the best of thy knowledge, death occurred at the time, date and place, and due to the cause(s) and marine as stated.

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

MAGMUUD 1ARZIQ 31. Date filed (Month, Day, Year)

JAN 2 0 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



DHMH 16 Rev 6/95

State

Registrar

Physic: /Medi		1 - State Amend Item 2. 1 - State Registrar 1. Decedent's Name (First, Middle, Last)	Mae	Ellis		2	Date of Death Month Day January 2	Year 2, 2005	3. Time of Death 5:20 p.	
Examir		4a. Facility Name (If not institution, give s	street and number) ien Nursing H	lome	4b. City, Town, or I	Colun			oward	
Funeral Director		218-18-6316	7. Ag	e (In yrs. last birthday) 82 Yrs.	tf Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Year) ovember 4, 19		place (State or Fore intry) Maryland	
of show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Hov	ward	10c. City, Town or Lo		olumbia			10d. Inside City Liπ 1 ☐ Yes 2 X ☐	
23e or 28e	al Director	10e. Street and Number 6334 Cedar Lane			10f. Zip Code	21044		en of What Cou U.S	.A.	
if, or items	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Pivorced	12. Was Decedent Armed Forces? 1 Tyes 2 th If Yes, Give Year or Dates:	No	Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 🔀 No	panic Origin? (Specif , Mexican, Puerto Ric Specify:		4. Race - Ameri Black, White Specify:		
should be filed within 72 no and Mental Hygiene. s marked other than "natur. sumatic event, the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5	(Give	DO NOT use retired)	iring most of working	16b. Kir	nd of Business/Ir	ndustry rnment	
	Be	12 17. Father's Name (First, Middle, Last)	I E. Ellis				First, Middle, Maiden	Maiden Sumame) e Wannenwetsch		
	2	19a. Informant's Name/Relationship (Ty	Route Number, City or	Town, State, Zi						
ant: If		Ms. Laura A. Jones Niece 6824 Autumn View Dr. Sykesville, Maryland 21784 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) All County Cremation Services, Inc. 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) All County Cremation Services, Inc. 21 Signification of Facility								
Departr importe any inji		23a. Part1. Enter the disease, or complishock, or heart failure. Vist only or	ications that ceused	alut I	Slack Fi	uneral Home, f	A Fllicott City	MD 21043	Approximate the the roat Between	
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e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√2 No 9 □ Unknown	d. 3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		2	3d. Date of deliv	rery Day Year	
pe de	by	Part II. Other significant conditions con	ntributing to death b	out not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobacco u	se contribute to		
	Completed						24a. Was an autopsy performed?	prior to co	opsy findings avail ompletion of cause 2 No	
after death. Director: After this certificate I in by the funeral director, pag	Certification: To Be	25. Was case referred to medical examiner? 1	28a. Date of Inju (Month, Da	ent 2 ER/Outpatier 17 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury	28c. Injury Work M 1 TY	at 280	Check only one) 5 Residence 6 d. Describe how injury f. Location (Street and City or Town, State)	occurred d Number or Rur		
within 24 hours after To the Funerel Direc completely filled in by	edical Cer	29a. Certifier 1 Certifying Physic (Check only 2 Medical Examions)	sician: To the best ner: On the basis o and manner sta	of my knowledge, death f examination and/or in ated.	n occurred at the time vestigation, in my op	e, date and place, and inion, death occurred	d due to the cause(s) at the time, date and	and manner as : place, and due !	stated. to the cause(s)	
within To the comple	Mec	29b. Signature and title of certifier	m1)		29c. License	number 370 9	29d. Date	signed (Month,	Day, Year)	
	1 /	30. Name and address of person who co	ampleted cause of d	looth (Item 22a) (Type	Drint\		Pawie			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible
State of Maryland / Department of Health and Mental Hygiene

		For	epartment of Health and M Ce <i>rtificate of Death</i>	lental Hygiene					
۰		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death				
Physici /Medio		Olayinka Fawehinmi		January	2, 2005 5:50 A M				
Examir	ier	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death Trince Georges				
		Doctor's Community Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Lanham day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year,					
Funeral Director		577-23-8509 1□ M 2⊠F 41 Yr	Months Davs Hours Min.	Nov 18, 19	() Country				
		Usual Residence of Decedent			10d. Inside City Limits				
nylan show	_	10a. State 10b. County 10c. City, Town of			11€ Yes 2 □ No				
8a-1s	Director	MD Prince Georges	Greenbelt 10f. Zip Code	100 C	itizen of What Country?				
with the	Dire	10e. Street and Number	20770						
eath ys 23	era	5906 Sherwood Terrance Apt 1 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	U.S.A. 14. Race - American Indian,				
fter d	Funeral	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	Rican, etc.)	Black, White, etc.				
Pal', o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	TO Fes 242 No Specify.		Specify: Black				
72 h 72 h	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired)	ing 16b. h	Kind of Business/Industry				
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shou and M and M		100.110.110.110.110.110.110.110.110.110	Mailing Address (Street and Number or Run						
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mit. Pages partment of portent: If It portent: If It y injury or otes.		`4 □Donation 5 □ Other (Specify) Fort Li	ncoln Cemetery 1/1 22. Name and Address of Facility For	- /	ntwood, MD				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hyglene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other treumatic event, the Medical Exercities constituted at ance.		21. Signature of Funeral Service Licensee	3401 Bladensburg R						
		23a, Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.			Approximate Interval Between				
Physician /Medical Examiner	niner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Immediate Cause (Final disease or injury that initiated events a. Due to (or as a consequence of Due to (or as a consequence of Cause (Disease or injury that initiated events	ATIC CARCINOM):	4 OF BR	Onsat and Death 4 YORS				
cate be executed physician and the burial-transit	dicai Examiner	d							
requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	hysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year				
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	lon:	Natural 5 Pending	me of 28c. Injury at york? M 1 ☐ Yes 2 ☐ No	Zou. Describe now in	ary coouries				
VISIC Attender or death rector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farr building, etc. (Specify)		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)				
To the Hospital or within 24 hours aft To the Funeral Dil completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, Check only one) 2 Medical Exeminer: On the basis of examination and manner stated.	death occurred at the time, date and place, /or investigation, in my opinion, death occu	, and due to the cause(rred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)				
To the within 2 To the complex	Me	29b. Signature as the of students	29c. License number D24093		Pate signed (Month, Day, Year)				
2		30. Name and address of person who completed cause of death (Item 23a) (TMARK PARICHURST ND 57)	Type, Print) II SARVIS AVE TO	LIVERDALE	EMD 20737				
St Regis	ate trar	31. Date filed (Ment) Day Year) 32 Degistrar's Signature	board .						

Registrar
DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene - State Registra MEND ITEM #8 PER FH G839 1/28 NOTICE of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** LINDA **FEHLAUER** 10:40 P.M 01 15 -2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WILLIAMSPORT WASHINGTON HOMEWOOD WILLIAMSPORT AT If Under 1 Year If Under 24 Hrs. 8. Date of Birty 21-19 Birthplace (State or Foreign (Month, Day, Year) 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min. 1□M XXF 220-14-8870 94 Director DELAWARE Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h Counts 28e-1 show the Medical Examiner must be notified at WILLIAMSPORT 1 ☐ Yes 🎾 No WASHINGTON MD. Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21795 16505 U. S. A. 238 VIRGINIA AVENUE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XX10 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2XXNo Specify: WHITE Specify: δ XX Widowed 4 □ Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOUSEWIFE YEARS 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ss 1 and 2 should be fill of Health and Mental Hittem 27 le marked otl GRIESBACH OSWALD EVA WOLFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 17906 CARTER LANE, HAGERSTOWN, MARYLAND, KENNETH R. FEHLAUER (SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ott WBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 01-20-2005 TIMONIUM, MARYLAND DULANEY VALLEY M.G. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 1050 YORK ROAD 4. Kuto RUCK TOWSON FUNERAL HOME, INC. TOWSON.MD.21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e. ch line. Approximate Interval Between Onset and Death Immediate Cause (Final as Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions. Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury the burial-transil that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.O. I 1 Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. à 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No certificate Yes Division of Vital 25. Was case referred to medical director 26. Place of Death (Check only one) Be examiner's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA 2 this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 28c. Hospitel or Attending Pl 24 hours after death.
 Funerel Director: After th 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide within 24 hours a To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month. Day, Year) 29b. Signature and title of person who complet cause of death State JAN 2 0 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0.05

			State of Maryland / Department of Health and Mental Hygien 1 - State of Maryland / Department of Health and Mental Hygien 1 - State of Death State of Death Reg. No.	1
	Physic	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 2. Date of Death Month Day Year	4
	/Medi Exami	cal	GLORIA SLYVINE GODWIN January 17, 2005 2 PN 4a. Facility Name (If not institution, give street and number) / / 4b. City, Toym, or Location of Death / 4c. County of Death	
			Maryland Greneral HUSPITED Baltimore CFTY Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Bale of Birth 9. Birthplace (State or Foreign	ın.
	Funeral Director		5. Social Sector by Number 6. Sex 147-40-1602 1 M 2DF 55 Yrs. 1 Months Days Hours Min. 1 March 04, 1949 9. Birthplace (State or Foreign Country) MARCH 04, 1949 MARCH 04, 1949 MARCH 04, 1949 1 MARCH 04, 1949 MARCH 14,)
	riand		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits	;
	e Mary 8e-f sh diffed	ctor	MARYLAND NIA BALTIMORE CITY 18 Yes 2 INC)
	death with the Maryland ms 23e or 28e-f show court be notified at	Dire	10e. St/eet and Number 418 MANSE COURT 10f. Zip Code 10g. Étitzen of What Country? 418 MANSE COURT 21201 45A.	
	r death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
11	vithin 72 hours after ene. then "neturel", or Ite	by	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No Specify: Specify	
3	21215-0036 d within 72 hours af giene. er then "neturel", or the Mudical Exam.	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry	
100	d withir giene.	Somp	Elementary/Secondary (0-12) College (1-4or 5+) YYRS NURSE PRIVATE DUTY	
C.	and I be file ntal Hy ed othe	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) AGURS 18. Mother's Name (First, Middle, Maiden Sumame) BEATRICE DAVIS	
B	Maryland 2121 d 2 should be filed within th and Mental Hygiene. 27 Is marked other then treumatic event, ILL M.	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	7
2	e, Marath and 2 Health a sm 27 letther tree		LAKISHA M. COOPER (DAUGHTER) SOL LAURENS ST. SALTIMORE MD. 2/2/1 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State	_
1/6	altimore, mit. Pages 1 a partment of Heaportent: If item y injury or othe ca.		1 Burial 2 Cremation 3 Removal from State Loffathe Temperature 1 - 25-05 Woodlawn Loffathe Method (Specify)	
9	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel, or Items 23e or 28e-1 show environty or other treumatic event, the Mydical Examinations be notified at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN JR, FUNERAL HOM 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN JR, FUNERAL HOM 21. Signature of Funeral Service Licensee	E 7
	100		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	-
	Examiner	L	Sequentially list conditions b. ARRhy Thmia	
	nted insit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	
	18760, icate be executed physician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):	
		edical	d	
	Box 6 death certific	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Check (pregift) Month Day Year	
	. 0 0 0	Physician/M	If the past 12 florings 1 d □ Pregnant at time of death 5 □ Other (specify)	
	Records, P.O. The law requires that the ste has been signed by the page 2 should be detach.	by	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	n
	ecord	Completed	24a. Was an autopsy findings available autopsy prior to completion of cause of	е
			performed? death? 1 Yes 2 No 1 Yes 2 No	
	of Vital F Physicien: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	
	ing Ph	lon: T	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	
	Division of Vital Records, To the Hospitel or Attending Physicien: The taw requires the within 24 hours after death. To the Funerel Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be	Certification:	Accident 3 Suicide 4 Homicide A Could not be determined 288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 286. Location (Street and Number or Rural Route Number, City or Town, State)	-
	Spitel o		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
4	the Horin 24 h the Fur hpletely	ledical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	_
	To To con	N N	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 1/17/05	
	510		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mir Shafiee, M.D. To Maryland General Hospital	
	St Regis	ate	31. Date filed (Month, Day, Year) JAN 2 0 2005 32. Registar's Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Eli Zabeth 2005 00A TAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min 52 MARBLE HALL KOAD 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 □ M 2 X F 218-29-0772 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1X Yes 2 □ No Funeral Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? KOAL 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status (UNKNO:UN) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced LAC Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 Is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) BER (UNKNOWN) 18. Mother's Name (First, Middle, Maiden Sumame) (MN KNO เมเบ 17. Father's Name (First, Middle, Last) (עונים מאלעט עו Be 19b. Mailing Address (Street and Number or Rural Houte Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 28 JOSEPH KNOXUR. (FRIEND) MARBLE HALLKO 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State perrit. Page Department of Important: if any injury or once. 01-20-05 WOODLAWN, MD * 4 ☐ Donation 5 ☐ Other (Specify) NG MEM. PARK 22. Name and Address of Facility BROWN TR. FUNERAL JOSEPH H. BROWN TR. FUNERAL 3140 N. FULTON AVE., BALTO, MA 21. Signature of Funeral Service Licensee Home MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory afrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) one year **Physician** Stenosis a or tic /Medical Due to (or as a consequence of): **Examiner** end stone CX De 3 resoldisease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed tricusoid value educardi his Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physiclan/Medical obstucto From 1 m 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Tobably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 2 1 M or Attending Phyaician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manny of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 Momicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 054018 BUK. Llen January 18 you? 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Patrice Green

31. Date filed (Month, Day, Year)

2005

3333 N. Calunt St. 655B 32. Registrar's Signature

Ba Itmae

CPM Nathan Nathaniel Gulliver 05-00258 Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1,20a-c, perFH, 6839, 1/20/05 Trible State of Maryland / Department of Health and Mental Hygiene UNK 05-00258 1 - For State Registrar 005 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 10, **Physician** Gulliver 2005 Nathan Nathaniel 20:05 /Medical 4a. Facility Name (If not institution, give street and number)
541 West 27th Street 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7/1956 inthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 84.48.066 Days 15KM 20 F Director Usual Residence of Decedent 10c. City, Town or Location -10d. Inside City Limits 10b. County 10a State 28e-f show other treumatic event, the Medical Examiner must be nutified at Baltimore MYes 2 NO MD Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21211 U.S.A. 27th Street West Items 23e Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 ☐ Widowed 4 ☑Divorced "neturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hyglene. Important: If item 27 is marked other then "ready injury or other treumatic event, the Mad ance. Elementary/Secondary (0-12) College (1-4or 5+) Officer Secunto Probation 12th arade Hyears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leon Gulliver, Sr. Regina Horshaw 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10704 Birdie Lane Upper Mailboro MD Sister Shan L. Gulliver 20b. Place of Disposition (Name of cemetery, crematory of other place)

Church of Christ Cemetery Coatesville, PA 20a. Method of Disposition 1/21/05 1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn (Green Fullial Service SISI Baitimore National Pike Baitimore MD 21229 21. Signature of Funeral Service Licenses au 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) head Gunshot of wound **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached to 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 X Yes 2 No Hospital or Attending Physiclen: 24 hours after death. Funeral Director: After this certifice funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6X Other (Specify) SCENE 1 X Yes 2 ☐ No 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural subject was shot 1 ☐ Yes 2 🗖 No 1-10-05 19:45 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 541 West 27th Street 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Nomicide Baltimore Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

25 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Dwelling To the Hospital within 24 hours at To the Funeral D 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier O.C.M.E. January 11, 2005 7 ho. mid

State

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month Day 2005

LIN4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 egistrar's Signatu

			_ FOI	Maryland / Depa			ntal Hygie	ne		
			1 - State Registrar	Ce	rtificate of D			Reg. No 2005 01120		
	Physici		1. Decedent's Name (First, Middle, Last)	Green	produ	2	Month	Day ZOUS	G: 58 A M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number	er)	4b. City, Town, or L	ocation of Death		4c. County of Death		
		•	Carroll Hospital Cer	ter		stminste		Cour		
	Funeral Director		218-01-0346	Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	Hours Min. N	Date of Birth (Month, Day, Ye 10V.2,191	9. Birth Cou	place (State or Foreign ntry) MD	
	and		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	ocation				10d. Inside City Limits	
	Marylan a-f show	tor	MD CARROLL	FINK	SBURG				1 ☐ Yes 2 ☑ No	
	or 28	Dire	10e. Street and Number		10f. Zip Code	01010	10g.	Citizen of What Cou		
	s 23a	ral	3216 PATAPSCO ROAD 11 Marital Status 12, Was Decede	at Ever in II S 12	Was Decedent of His	21048	fu Vac or No	14. Race - Ameri	USA can Indian	
336	be filed within 72 hours after death with the Maryland hat lygiene. do other then "naturel", or flems 23a or 28a-1 show svent. I're Medical Evaniral te notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Was Decede 1 □ Yes 2 □ If Yes, Give 7 ear or Date	s? X) No	If Yes, specify Cuban,	Mexican, Puerto Ri	can, etc.)	Black, White,		
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21215-0036	filed within 7 Hygiene. ther then "r int, the Med	Completed	Elementary/Secondary (0-12) College (1-40	or 5+) life.	DO NOT use retired) KEEPER	ang most or norming		ITERNAL RE	VENUE SVC.	
	be filed tal Hygi d other svent, I	Be C	17. Father's Name (First, Middle, Last)		1	18. Mother's Name (i	_			
Maryland	yes 1 and 2 should of Health and Mer II item 27 Is marke or other traumatic	၉	DAVID 19a. Informant's Name/Relationship (Type, Print)	JACO 19b. Maili	BSON ng Address (Street an	ELIZABET and Number or Rural F	··-	ABJNOWJTZ ty or Town, State, Zij	Code)	
			DAVID GREENBERG / SON		SOUTH SHOR					
altimore,			20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from Sta 4 □ Donation 5 □ Other (Specify)	10	osition (Name of matory or other place) NAH (AITZ			Location - City or T R∆I TIM	ORE, MD	
Baltir	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Ligensee	22	2. Name and Address 900 REISTE	of Facility SOL	LEVINSON	l & BROS.,	INC.	
			23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	sed the death. Do not en				LOVILL,	Approximate Interval Between	
ja j	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Acut	e pe	ritonitis	>		Onset and Death	
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oʻ	cate be executed oblysician and the burial-transit	Examin	that initiated events c.	as a consequence of):						
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.O. Box 6	The law requires that the death certific lie has been signed by the attending is page 2 should be detached for use as	Physician/Me		2 Fetal death 3 at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	ery Day Year	
0_	ires that the signed by detaction	ρλ	Part II. Other significant conditions contributing to death	but not resulting in the u	inderlying cause given	n in Part I.	23e. Did tobacc	co use contribute to t	he cause of death?	
Records,	w require s been si should b	oletec	(1/2				24a. Was an	24b. Were auto	ppsy findings available	
I Re		Completed					autopsy performed	death?	mpletion of cause of 2□ No	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	/	Other	26. Place of Death (
of	Phys this ral dir	To	1 Yes 2 No 1 Sphall 1 No. 27. Mann r of Death 28a. Date of It (Month, It (Mon			4 Nursing Home	 5 Residence d. Describe how in 	 6 ☐ Other (Special injury occurred) 	(y)	
lon	nding F th. : After e funer	atlor	1 Vatural 5 Pending (Month, 1) 2 Accident investigation	Day Year) Injury		es 2 No				
Division	I or Attend after death Director: \f	Certification;	3 Suicide 6 Could not be 28e. Place of	Injury - At home, farm, streetc. (Specify)	reet, factory, office	28	f. Location (Street City or Town, St	t and Number or Run tate)	al Route Number,	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 1. Certifying Physicien: To the besidence on the design of the desi	of examination and/or in	h occurred at the time vestigation, in my opin	, date and place, and nion, death occurred	d due to the cause at the time, date	e(s) and manner as s and place, and due t	stated. to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier		29c. License	_	29d.	Date signed (Month,	Dey, Year)	
	1		Im (free M	0		59943	Ja	unach 11	2003	
			30. Name and dedress of person who completed cause of Sim (Appl) M.D. 295	of death (Item 23a) (Type,	Print) Svite	307 W	stminst	W MD Z	4157.	
	Sta Registr		31. Date filed (Month, Day, Year N 2 0 20 75	of death (Item 23a) (Type,	& Sparke	ŝ				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Regist RAFND ITEM #10c PER FH C839 1/20/05 JH Reg. No. 2. Date of Death Month Day Year **Physician** 11:30 AN JANUARY 15,2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner ALTIMORE If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours 1**M**M 2□F MARVLAND Director the Maryland 10d. Inside City Limits 10a State MIDDLE 28a-f show treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 8 or Items 23a Completed by Funeral 12. Was Decedent Ev. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, of in U.S 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. Is marked other than "naturel", or Itel 2 Married 1 Never Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry odary (0-12) College (1-4or 5+) ABOREA 18. Mother's Name (First, Middle, Maiden Surnar Father's Name (First, Middle, Last), To Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Informant's Name/Relationship (Type, permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is rr eny injury or other treum once. EDISTO KIVEK, MD 2/220 WITE 20a. Method of Disposition

1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other Date 3 Removal from State VAYGHN C. GREENE FUNERAL HOME 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee BACTIMORE, MAKY LAND 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS - KLEBSIELLA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RENAL FALLE
Due to (or as a consequence of) FAILURE 4EARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit KLEBSIEZLA PNEUMONIA Due to (or as a consequence of) P.O. Box 68760, the attending physician eq Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 2 No 1 TYes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2□ No 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 1 Yes No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After t Certification: Hospitel or Attending I (Month, Day Year) Natural 5 Pending investigation 1 Yes 2 No 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 AU4/76435W1602 Walls. MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature WALLACE 201 E. UNIVERSITY 31. Date filed (Month, Day, Year) State JAN 2 0 2005

DHMH 17 Rev 1/2001

Registrar

		1 - For State Registrar	State of Ma	aryland / Dep		lealth and M	lental Hygi	_	01122
		1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month		3. Time of Death
Physic /Medi		Theodore E	. Herman				January	1 ^B 2005 ^{ear}	6:00 p M
Exami		4a. Fecility Name (If not institution, Stella Maris			4b. City, Town, o	or Location of Death		4c. County of Death Baltimore	
Funeral Director		349-12-0692	.07.1.	(In yrs. last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, March 4	9. Birthp 9. 1924 Illi	lace (State or Foreign htry) nois
boa *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location			1	0d. Inside City Limits
Manyla f sho	ō	Md. Baltir	nore	Timonium					1 ☐ Yes 2 ☑ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	Funeral Director	10e. Street and Number 223 Burning Tre	ee Rd.		10f. Zip Code	1093	10	g. Citizen of What Cour	ntry? ISA
ns 23	era	11. Marital Status	12. Was Decedent 8	Ever in U.S. 13	. Was Decedent of F	Hispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	
urs after o	by Fur	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? d 1 ☑ Yes 2 ☐ N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2 ☑ No		Hican, etc.)	Black, White,	etc. ite
2 hou	ted	15. Decedent's (Specify only highest	Education	16a. Dec	edent's Usual Occup	oation during most of work d)	ina 1	6b. Kind of Business/In	dustry
within 72 nne. than "na	Completed	Elementary/Secondary (0-12)	College (1-4or 5	4)			9	FDA	
led w lygier her th		47 Fabrica Maria (Fina Middle I	+2	1000	Inspecto	18. Mother's Name	- /First Middle M		
ould be file Mental Hy arked oth	Be	17. Father's Name (First, Middle, L Linus A. Herma				Edith		erson	
d Me mark matic	70	Linus A. Herma		19b. Ma	ilina Address (Street			City or Town, State, Zip	Code)
d 2 s lth an 27 ls		Nancy Herman/ 1						Md. 21093	
t Healten		20a. Method of Disposition			position (Name of ematory or other pla		7	0c. Location - City or To	wn, State
Page: ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation : 1 ☐ Donation 5 ☐ Other (Spe	B □Removal from State confy)		Service C	1	05	Towson, Md.	
permit. Pages Department of Important: If It any injury or o		21. Signature of Faperal Service V			22. Name and Addre	ss of Facility	al Uemo	Tac	
9 0 m # 0			125		1050 Yor	son Funer k Rd. Tow	son. Md.	21204	
Physician /Medical Examiner		23a. Part 1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	a. <u>LUNG</u> CA	10.	nter the mode of dyll	ng, such as cardiac (or respiratory arres	St,	Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Clustees or injury that initiated events	C	a consequence of):					
icate be executed physician and s the burial-transit	icai	resulting in death) Last	Due to (or as a	a consequence of):					
The law requires that the death certificat site has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	☐Ectopic pregnanc	у		23d. Date of delive Month	ery Day Year
w requires that the been signed by should be detact	by	Part II. Other significant condition	s contributing to death bu	ut not resulting in the	underlying cause gr	ven in Part I.		acco use contribute to the	
Phyeicien: The law req this certificate has beer al director, page 2 shou	ompieted						24a. Was an autopsy perform 1 Yes 2	ed? prior to co	psy findings available inpletion of cause of 2 No
	3e C	25. Was case referred to medical					h (Check only one		
hyeic his ce I direc	To B	examiner? 1 ☐ Yes 2 🗶 No		nt 2 ER/Outpati	ent 3 DOA			nce 6 Other (Specif	HOSPICE
ng utter		27. Manner of Death 1 X Natural 5 Pending 2 Accident investigs	28a. Date of Injur (Month, Day	Year) 28b. Time Injury	Wo	ry at rk? Yes 2 □ No	28d. De <i>s</i> cribe hov	v injury occurred	
To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification;	3 Suicide 6 Could no 4 Homicide determin		ury - At home, farm, : :. (Specify)	street, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	il Roule Number,
To the Hospital or within 24 hours afte To the Funerel Dir completely filled in	edical C	29a. Certifier 1X Certifying (Check only one)	Physician: To the best of caminer: On the basis of and manner sta	examination and/or	ath occurred at the ti investigation, in my o	me, date and place, opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as site and place, and due to	ated. the cause(s)
omple	Me	29b. Signature and title of certifier)		29c. Licens	se number	29	d. Date signed (Month,	Day, Year)
F S F O			/5-		D	4372	S	1/19/03	
· ·		30. Name and address of person w	ho completed cause of de	eath (Item 23a) (Typ				/ /	
5+1		DR. TARIQ MAH		DULANEY VA		TIMONIUM	, MD 210	93	
Sta	ate	31. Date filed (Month, Day, Year)	2005 32. Registra	ar's Signature	books				

6:00 p.m.

JANUARY 18, 2005

THEODORE HERMAN

				State				Health and M	•	niene»	0.	
		•	For Stata Registrar	State o	i Marylanu	•	rificate of		_	Reg. No.	05	01123
Р	hysicia	n	1. Decedent's Name (First, Min	ddie, Last) IZABETH	HARTMAN				2. Date of De.	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institu				4b. City. Town.	or Location of Death	Januar	4c. County		3:05/1
	xamin	er	Franklin S	Solvare He	ospital		Ro	sedale		Bal	1 .	ore
	neral ector		5. Social Security Number 215–14–9254	1 M 2X F	7. Age (In yrs. las	st birthday)_ Yrs.	Months Days		8. Date of Birt (Month, Da 4-29-1	y, Year)		ace (State or Foreign try) YLAND
			Usual Residence of Decedent		10a City	Town or Loca	ation		4-29-1	910		Od. Inside City Limits
1215-0036 within 72 hours after deeth with the Maryland	-t show lied at	tor		ALTIMORE	Too. Oily,	TOWN OF LOCA		SEDALE				1 ☐ Yes 2 🛣No
th e	rthen "netural", or fems 23a or 28e-1 shov the Medical Evan fer must be collified at	Funeral Director	10e. Street and Number				10f. Zip Code	24.025		10g. Citizen of V		try?
leeth w	ns 23a	eral	1525 NEIGHBO	12. Was Dece	edent Ever in U.S.	. 13. W		21237 Hispanic Origin? (Spe	ecify Yes or No		S.A. e - America	an Indian,
36	or Item		1 ☐ Never Married 2 ☐ M	Armed Fo 1 ☐ Yes If Yes Giv	rces? 2 XNo /e		Yes, specify Cub □ Yes 2 💢 No		Rican, etc.)	Blac Specify	k, White, e	
5-0036 72 hours aft	cal Exc	ed by	3 XWidowed 4 ☐ Divord	lent's Education		16a. Decede	nt's Usual Occu	pation		16b. Kind of Bu	MH	LTE lustry
21215 within 72	Media	Completed	(Specify only hig Elementary/Secondary (0-12	hest grade completed) 2) College (1	-4or 5+)	life. De	O NOT use retire		ng			_
C D E	event, the	e Cor	6 17. Father's Name (First, Midd	le, Last))	P.	RESSING	MACHINE 18. Mother's Name	(First, Middle,		INTIN	G
Aland be Menta	9 6	To B	GEORGE D	I MATTEI				AGNES	(PORK	ENY)		
ar ar	trau		19a. Informant's Name/Relation FRANCES MC DO		אביויו			t and Number or Rura ORS AVENUE		ALE, MD	State, Zip	
Or N, or t and 2	tem 2		20a. Method of Disposition		20b. Plac	ce of Disposi	tion (Name of	D	ate	20c. Location -		
altimore,	Jury or		1 Burial 2 Crematic	(Specify) ENTOME	State	KIAWN (CEMETERY	1-20	-2005	BALTIN	MORE,	MD
Baltimo	any in		21. Signature of Funeral Servi	ce Licensee			Name and Addr	ess of Facility CVA SACO AVENU		EDALE FU		L HOME 237
7			23a. Part1. Enter the disease shock, or heart failure. L	or complications that c ist only one cause on e	aused the deeth. ach line.							Approximate Interval Between
	ician		Immediate Cause (Final disease or condition resulting in death)	- a Phei	<i>Amonia</i>	1						Onset and Death
	dical niner			Due to (or as a conseque	nce of):						
/ / P	75	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (oras a conseque	nce of):						
60,	burial-transit	Examiner	that initiated events resulting in death) Last	c	or as a conseque	nce of):						
	ysicie ne bui	ca		d								
× 68	attending phy for use as th	/Med	IF FEMALE:	23c. If yes, out	come of pregnanc	ev				22d Date	e of deliver	
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physicien: The law requires that the death certifica within 24 hours after death.	d for u	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \)	1 ☐ Live b 4 ☐ Pregn	irth 2 Fetal deant at time of dea	eath 3 □E	ctopic pregnand Other (specify) _	:у		Mon		Day Year
P.O	detached for	Phys	9 Unknown	9□ Unkno		ing in the unc	larhing cause of	van in Part I	23e Did to	phacco use contri	ibute to th	e cause of death?
Division of Vital Records, tor Attending Physicien: The law requires that recently.	should be o	d by	Bastric	out let	Obstru	ictio		VOITHIT CITT.	1 🗆 Y	1/	3 Proba	
ecoi	nas beer	Completed	Chronic	Renal	failu	ire			24a. Was	an 24b. W	Vere autop	sy findings available
al Re			•						perfo	rmed? d	eath?	2 □ No
Vita	Scerif	To Be	25. Was case referred to med examiner? 1 Yes 2 No	Hospital: V	npatient 2 EF	R/Outpatient	3□ DOA Ot	26. Place of Death her: 4 ☐ Nursing Hon		ne) dence 6 □Othe	or (Specify)
n of	uneral (27. Magner of Death 1 Natural 5 □ Pen	ding 28a. Date of (Mont		8b. Time of Injury	28c. Inju	ry at 2		now injury occurre		
Divislo Nor Attendi	y the fu	ficati	2 Accident inve 3 Suicide 6 Cou	stigation 28e. Place	of Injury - At hom	e, farm, stree		Yes 2 No		Street and Numbe	er or Rural	Route Number,
Div	filled in by the	Certification:	4 Homicide	buildi	ng, etc. (Specity)				City or Tow	vn, State)		
Hospi 24 hou	completely filled	edical	29a. Certifier 1 Certification (Check only one)	ying Physician: To the al Examiner: On the ba and mann	best of my knowle asis of examination per stated.	edge, death on and/or inve	stigation, in my	ime, date and place, a opinion, death occurre	and due to the o ad at the time, o	cause(s) and mar date and place, a	nner as sta nd due to	ated. the cause(s)
To the	comple	Me	29b. Signature and title of cert				29c. Licen			29d. Date signed		-
			* dolly	5 Mille	UU, MD.		1)(2061418		1-16	> - (05
	6		30. Name and address of pers	on wito completed caus	e of death (Item 2			2 Drive,	Raltin	1-16	0 21	237
	Stat	·	31. Date filed (Month, Day, Ye	ar) 32. R	egistrar's Signatur	е	9			1		
F	legistra	ir	JAN	2 0 2005	2.000	1 60	eres)					

		-	For State Registrer	State of Ma	aryland /	-	artment tificate					giene Reg. N2 ()	05	0.1	124
	Physicia /Medic	_	1. Decedent's Name (First, Middle, La William H. Hurle								2. Date of De Month January	Day	Year 005	3:58	of Death
	Examin		4a. Facility Name (If not institution, gi 20 Margate Road	ve street and number)				Town, or ervi	Location o	of Death			y of Death	<u>.</u>	
	Funeral Director		Social Security Number 6.	Sex 7. Ag 1 M 2 ☐ F	e (In yrs. last b	oirthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bird (Month, Da Dec. 14	h y, Year)	T	place (State ntry)	e or Foreign
	vith the Maryland or 28a-f show		Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo 10e. Street and Number	re	10c. City, To		le 10f. Zip					10g. Citizen of	What Cou	ntry?	City Limits
9036	72 hours after death with the Maryland rieturel', or Items 23a or 28a-1 show dical Examinar must be mutified at	d by Funeral	20 Margate Road 11. Marital Status 1 □ Never Married 2 □ Married 3 🌣 Widowed 4 □ Divorced	If Yes, Give Korea Year or Dates:			21093 Was Decedent of Hispanic Origin? (Speif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:			ecify Yes or No Rican, etc.)	Speci	ce - Ameriack, White	can Indian, , etc. te		
Maryland 21215-0036	be filed within ital Hygiene. Id other than "event, the We	Completed	15. Decedent's 8 (Specify only highest g Elementary/Secondary (0-12)	Education rade <i>completed)</i> Coflege (1-4or t		(Give	kind of work done during most of working DO NOT use retired) Lone1				United St Air Ford		-		
ryland		To Be (17. Father's Name (First, Middle, Las Harlow Hurley 19a. Informant's Name/Relationship					18. Mother's Name (First, I Ruth (Not A			ot Avai	lable)		o Code)	
Baltimore, Ma	l and 2 s Health ar Im 27 is ther trau		Candis Morrison / 20a. Method of Disposition 1 \(\text{M} \) Buriel 2 \(\text{Cremation} \) Cother (Specification)	Daughter ☐Removal from State	20b. Place ArTT	1298 of Dispo	May esition (Name Party at Party	Chap ne of To nac	el R	oad, Februa	Timoni ry 9,	um, Mar 20c Location Arlingt	yland - City or T on, V	d 2109 own, State	nia
Balti	permit. Pages. Department of the Important: If Its any injury or of once.		21. Signature of Funeral Service Light	MO	1353							Pumphre 7557	y Fu Wisc	neral onsin	Home Avenue
1760, -1	Physician /Medical Examiner	Ical Examiner	23a. Pert1. Enter the disease, or conshock, or heart failure. List only find disease or condition resulting in death) Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Acute M Due to (or as Coronar Due to (or as	ne. yocardi a consequenc	al l e of): y Di e of):	nfar	ction						fritervaf E Onset ar	
.O. Box 68	that the deeth certificat ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetaf dea		□Ectopic pi □ Other (sp						ate of deli	very Day	Year
<u>α</u>	quires that n signed b uld be deta	b	Part II. Other significant conditions Diabetes Mellitu		out not resulting	g in the u	nderlying o	ause give	en in Part	l. ——		obacco use co Yes 2 🕅 No			
I Records,	The lew requires that the rate has been signed by the page 2 should be detache	Completed	End Stage Renal Congestive Heart								24a. Was auto perfo 1 \(\text{Yes}	psy ormad?	prior to c death?	opsy findin ompletion o	gs available if cause of
Division of Vital	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 No					28c. Injun Worl	er: 4□N	ursing Ho	28d. Describe	dence 6 00 how injury occu	urred		lumber,
Div	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determine 29a. Certifier 1 Certifying (Check only 2 Medicel Ex	28e. Place of Inbuilding, e Physician: To the best	tc. (Specify) of my knowled	ige, deat	h occurred	at the tin	ne, date a	nd place,	City or To and due to the	cause(s) and r	nanner as	stated.	e(s)
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifier Adn 7.	and manner s	tated.			c. Licens	e number			29d. Date sign	ed (Month	, Day, Yea	r)
	JOY1 Str Regist	ate	30. Name and address of person wt John L. Marra, M 31. Date filed (Month, Day, Year)	D., 5601	death (Item 23a Loch Ra rar's Signature	ven		, Ba			MD. 21	239			

			For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of F rtificate of			giene2 () Reg. No.	05	01125
	Physici		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	Дау	Year	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give	7/1		4b. City, Town, o	r Location of Dea		4c. County		
	LXAIIIII	iei	Suburban Hospita	.1		Bethes	da		Monts	gomer	V
	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year		8. Date of Birt	h		lace (State or Foreign try)
	Director		506-07-5749	X M 2 □ F 8	4 Yrs.	Months Days	Hours Min	March 2	1920	Nebra	aska
	PL		Usual Residence of Decedent		100 City Town and						ad tasida dia kinin
	show	_	10a. State 10b. County Maryland Montgom	0.837	10c. City, Town or Lo					11	0d. Inside City Limits 1 ☐ Yes 2XXNo
	Ba-f	cto	,	ely	TOCOMA						
	vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V		•
	s 23e	irai	11913 Falls Road	12. Was Decedent E	vos in II C 12 1		0854	Casaify Von or No	United	Stat - America	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "naturel", or Items 23e or 28a-f show event, its Medical Era client mat be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Acmed Forces? 1 12 Yes 2 1 N If Yes, Give Year or Dates:	o MMTT	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	to Rican, etc.)		k, White, e	etc.
9	2 hou		15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Bu	siness/Ind	lustry
715	in 7	Completed	(Specify only highest gri Elementary/Secondary (0-12)	ade completed) College (1-4or 5-	(Give	kind of work done DO NOT use retired	during most of wo d)	orking			
212	d with	E	cionionaly/Socondary (0-12)	4		tor /Arb	itrator		Federal	LGov	ernment
Þ	e filed within al Hygiene. I other then vent, the Ma	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle,	Maiden Sumam	е)	
Maryland		To B	Thomas S. Ingle	S			Mary F	rances B	urris		
a _Z	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	,-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	and Number or R	lural Route Numbe	r, City or Town,	State, Zip	Code)
	T		<pre>Inge R. Ingles /</pre>	Wife	11913	Falls Ro	oad, Pot	omac, Mai	ryland 2	0854	
ē.	item		20a. Method of Disposition	ID	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	e) Jani	Date 18,	20c. Location -	City or To	wn, State
E	Pages nent of I int: If its iry or o		1 ☐ Burial 2 X Cremation 3 ☐ • 4 ☐ Donation 5 ☐ Other (Special		Montgomery (Bethesd	a, Ma	ryland
Baltimore,	permit. Pages 1 and Department of Heali Important: If item 2 any injury or other once.		21. Signature of Funeral Service Lice	mount	M01305 RO 30	Name and Addre bert A. Pun O West Mont	ss of Facility iphrey Fund gomery Ave	eral Home/Renue, Rocky	Rockville, ville, Man	Inc.	20850-2805
	*		23a. Part1. Exter the disease, or com shock, or heart lailure. List only	plications that caused to	the death. Do not ent						Approximate Interval Between
	Physician		Immediate Cause (Final	Anto	rioselere	Au Ca	Mine	1 ceille	1 Dote	200	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	JI TO Ca	141004	564191	PIJER	V1	
	Examiner										
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):						
V.7.	be executed sicien and burial-transit	Examiner	triat initiated events	C.							
oʻ	en an rial-tr	Exe	resulting in death) Last	Due to (or as a	consequence of):						
8760,	ate be physicii the bu	dicai	(d							
89	tiffica ng ph as th	Med	IE FCHAIC								
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Ectopic pregnancy	,			of deliver	•
	deat ne att ad for	sicie	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at t		Other (specify)			Mor	nth I	Day Year
P.O.	that the d ed by the detached	h	9 Unknown	3 Olklowii							
ŝ	res tha igned be det	by F	Part II. Other significant conditions			nderlying cause giv	en in Part I.			1	e cause of death?
p	w require been si should I		rena/	NSUFFIC.	iency			1 🗆 Y	es 2 No	3 Proba	ably 4 □Unknown
သို့	law re as be 2 shu	pie						24a. Was a	an 24b. V	Vere autop	sy findings available
æ	The I	Completed						enfor	mod2# d	eath?	
of Vital Records,	i cien: Th certificate rector, pag	a	25. Was case referred to medical				26. Place of De	ath (Check only or			
>	yeicien: is certific director,	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatien	t 2 ER/Outpatien	t 3 DOA Oth	er: 4 🗆 Nursing I	Home 5 Resid	ence 6 Othe	er (Specify,)
0	ding Ph After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of	28c. Injun Worl	y at k?	28d. Describe h	ow injury occurre	ed	
Division	uttendin death. ctor: Af y the fur	atic	2 Accident investigatio	n			Yes 2 □ No				
V.S	er de recto by th	tific	3 Suicide 6 Could not b	e 28e. Place of Injur	y - At home, larm, stre (Specify)	eet, factory, office		281. Location (S City or Tow	treet and Numbe n, State)	or or Rural	Route Number,
Ö	rs aft el Di ed in	Certification:									
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exer	ysician: To the best of niner: On the basis of and manner state	examination and/or inv	occurred at the tin restigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time, d	ause(s) and mar late and place, a	nner as sta nd due to	ited. the cause(s)
	To t Withi To tl	Ž	29b. Signature and title of certifier			29c. Licenso	e number	2	29d. Date signed		Ney, Year)
			Molh	lem		D39	1174		1/18/05	>	
-	0 (1.4		30. Name and address of person who	completed cause of de-	ath (Item 23a) (Type,	Print)					
	25+1		Robert Rothstein,	M.D. 8600	0 Old Geor	getown Ro	oad, Bet	hesda, Ma	aryland	2081	14
	Sta	ite	31. Date liled (Month, Day, Year)	32. Regetrar	's Signature	Coole					
	Registr	ar	JAN 2 (ZUUD COUL	130 P3 1						

LEW			State of Maryland / Department of Health and 1- For Unpend Item 23a,pt.II,27 per me 6841 3-2-05 tas Registrar	Mental Hy	giene 005	01126
			Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of D	eath	3. Time of Death
	Physici		William Darran Jarriel	Januar	v 14. 200	5 22:56 P. ^M
	/Medio Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea		4c. County of De	
			Upper Chesapeake Medical Center Bel Air 5 Social Sequity Number 5 Sex 7 Age (In vis. last birthday) If Under 1 Year If Under 24 His		Harford	
5	Funeral Director		1X M 2 F	. (Month, D		irthplace (State or Foreign Country)
7			Usual Residence of Decedent	Dec. 28	3, 1965 M	aryland
	inylan show		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ith the Marylar or 28a-f show e notified at	ecto	Maryland Harford Abingdon		10g. Citizen of What (
	with ti	Dire	10e. Street and Number 10f. Zip Code			Sountry :
	heath w	era	508 Eastview Terrace, Apt. 3 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (1) If Yes, specify Cuban, Mexican, Puel	Specify Yes or N	USA 10- 14. Race - Ar	nerican Indian,
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 le markad other then "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Exam actional be rediffied at	by Funeral Director	Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 1 Ves 2 No 1 Ves 2 N	no Hican, etc.)		White
5	72 hours "naturel", dical Exc	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of wo	orking	16b. Kind of Busines	ss/Industry
121	e filed within all Hygiene. I other than "rent, the Med	ldm	Elementary/Secondary (0-12) College (1-4or 5+)	iaian	Communi	cations
d 2	Hygie Hygie other	Co	12 Communications Techn 17. Father's Name (First, Middle, Last) 18. Mother's Na		e, Maiden Sumame)	Cacions
an	ild be lental kad c ic eve	To Be	William Alfred Jarriel Velma	Mae I	ogus:	
ary	2 should be f and Mental b le markad of raumatic eve	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Relationship)			/1009
	and 2 ealth m 27 I		Kimberly Jarriel/Wife 508 Eastview Terrace			
Baltimore,	ges 1 t of H if Iter or oth		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	
Ē	t. Pag rtmen rtant: njury		'4 Donation 5 Other (Specify) Gardens of Faith 01-	18-2005		e, Maryland
Bai	parmit. Pages 1 and 2 Department of Health a Important: if Item 27 le any injury or other tra once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Ho	me, P.A.	• •	21000
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	ac or respiratory	goon, Maryi arrest,	Approximate Interval Between
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a Steatosis of Liver and Early Cirrhe	ooia		Onset and Death
	/Medical		resulting in death) a. Steatosis of Liver and Early Cirric Due to (or as a consequence of):	0919		
	Examiner		Sequentially list conditions, b			
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	ate ba executed nysicien and he burial-transit	хап	that initiated events resulting in death) Last Due to (or as a consequence of):			
760,	sicien sicien					
89	tificati ng phy as the	Physician/Medical				
Вох	Attending Physician: The law requires thet the death certifical rdeath. sctor: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	an/N	IFFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live birth 2 □ Fetal death 1 □ Char (spitt)		23d. Date of o	telivery Day Year
O. E.	the at the at	/slcl	1			,
P.0.	thet the	Ph)	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
ds,	w requires the baen signed I should be det	d by	Myocardial Fibrosis	1 🗆]Yes 2 □ No 3 □	Probably 4/ Qunknown
COL	w requ	Completed by		24a. Wa	s an 24b. Were	autopsy findings available
Re	The lay te has age 2	omp		per	opsy prior t formed? death	o completion of cause of es 2 □ No
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	BeC	25. Was case referred to medical 26. Place of De	eath (Check only		
> >	Physic this ce	ToE	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2XER/Outpatient 3 DOA Other: 4 Nursing		sidence 6 Other (Sp	pecify)
n o	Jing P. After t funera		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?	28d. Describe	how injury occurred	
isio	ttendi death. ctor: A / the fu	Certification:	2 Accident 3 Suicide Suicide Accident Investigation Suicide Accident Accide	28f. Location	(Street and Number or	Rural Route Number,
Ο̈́	after Direction by	ertif	4 Homicide determined determined building, etc. (Specify)	City or To	own, State)	
	To the Hospital or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	alC	29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place	ce, and due to the	e cause(s) and manner	as stated.
	n 24 he Fu	Medical	(Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	curred at the time		
	To the within 2 To the complet	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	_
	has		Bert J. Walton W. W. O.C.M.E.		January 15,	, 2005
	LOLA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET BAI	TIMORE.	MD21201	
	Sta	ite	4200	,	3	
	Registr		31. Date filed (Month, Pay, Year) AN 2 0 2005 32. Registrar's Signature			
DH	MH 17 Rev 1/2	001	John Market			
			ORIGIÑAL			

			State of Manuford / Dona		•	•	
			State of Maryland / Department State of Maryland / Department State Stat	tificate of Death		200	01127
			Registrar 1. Decedent's Name (First, Middle, Last)	illicate of Death	2. Date of Death	No. 4 U U .	3. Time of Death
	Physicia		John Leonard Jenkins		01/18/2	Day Year	3:00A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	01/10/2	4c. County of Dea	
	Exaiiiii	C.	Millennium Health and Rehab	Glen Burnie		Anne Ar	undel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y 03/04/1	9. Bir	thplace (State or Foreign
	Director		220-20-6063		03/04/1	913	MD
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	Mary f sho	to	MD Anne Arundel Glen Bu	rnie			1 ☐ Yes 2 🛣 No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	ountry?
	th with		104 4th Avenue SE	21061		U.S.A.	
	r dea	Iner		Was Decedent of Hispanic Origin? (Spot Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
36	s afte	by Funerai	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 MINO If Yes, Give Year or Dates:	l ☐ Yes 2 X No Specify:		Specify: W	hite
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28e-f show the Medical Examiner must be notified at	ed b	15. Decedent's Education 16a, Decedentian 16a, Decedentia	dent's Usual Occupation	16	b. Kind of Business	
15	nin 72 n "ns	piet	(Specify only highest grade completed) (Give	kind of work done during most of work OO NOT use retired)	ng		•
2	d with giene er the	Completed	12 Bank	er	Fe	ederal R	eserve
ng	al Hy d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u> </u>	ould to Ment	L _o	Benjamin Jenkins		et Koerr		-
Mar	12 sh h and 7 is rr Ireum		19a. Informant's Name/Relationship (Type, Print) Grace Clare Burke/Daughter 104	Ath Aronio SE		-	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once.		20a Method of Disposition 20b. Place of Dispo	sition (Name of		c. Location - City or	
Baltimore,	ages int of t: If it y or o		1 ■ Burial 2 Cremation 3 Removal from State	w Mem Pk 01/2	24/05 51	kesvill	e. MD
	nit. P artme orten injur			. Name and Address of Facility G			
å	permi Depa Impo any ir			69 Riviera Driv			
	4. 9		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on ea hine.				Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition				Onset and Death
	/Medical Examiner		resulting in death) Due to (or w a consequence of):	X-0 1 -			
	Cxammer	L	Sequentially list conditions, Due to (or at a consequence of):	Desilely			
7	ped list	nine	Sequentially list conditions, it may be immediate cause. Enter Underlying Cause (Disease or injury				
, 	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):				
760,	9 % 0	cail	d				_
68	wrequires that the death certifical been signed by the attending phy should be detached for use as th		(SEEMALE)				
Вох	th cer tendir or use	an/h	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □	Ectopic pregnancy		23d. Date of de Month	livery Day Year
О. П	ie dea the at hed fo	/sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)			52,
P.O.	The law requires that the ate has been signed by th bage 2 should be detache	by Physician/Medi	Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
ds,	signe d be				1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown
COL	w req	Completed			24a. Was an	24b. Were a	utopsy findings available
Re	The law cate has page 2 t	omp			autopsy performe 1□ Yes 25		completion of cause of 2 □ No
of Vital Records,		a	25. Was case referred to medical	26. Place of Deatl	(Check only one)	10 10 10	
Į ∨	Physicien: r this certifica ral director, p	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	t 3 DOA Other: 4 ursing Ho	me 5 Residenc	e 6 □Other (Spe	ocify)
n o	ing Pl		27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 1 Injury	Work?	28d. Describe how	injury occurred	
sio	ttendi death. ctor: A y the fu	icati	2 Accident investigation	M 1 Yes 2 No	28f Location (Street	et and Number or R	ural Route Number
Division	l or Al after o Direc	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	City of Town,		orar roots romos,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director; After this certific completely filled in by the funeral director.		29a. Certifier Certifying Physician: To the best of my knowledge, death				
	ne Ho n 24 h ne Fui	edicai	(Check only one) Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	ed at the time, date	and place, and du	e to the cause(s)
	To the h within 24 To the F complete	ž	29b. Signature and Welpf certifier	29c. License number	29d	. Date signed (Mon.	th. Day, Year)
)			· Wo	D670Z	8 1	-19-0	5
	11		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	201 10		1:- 0:
	4		ADITYA CHOPRIA, M.D. (600 R 31. Date filed (Month, Day, Year) 32. Registrar's Signature	acigely Ave. Su	e. 231 H	nnapo	115, VND 21401
	Sta Registi		JAN 2 0 2005 Region & A	South &			
9,7	* *		JAIN 4 V (UU) Block of A				

Hospital or Attending Physician: within 24 hours a To the Funeral D

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THEODORE 32. Registrar's Signature 31. Date filed (Month, Day, Year)

29b. Signature and title of certified

JAN 2 0 2005

and manner stated.

OCME January 7, 2005 111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

h

State Registrar 29c. License number

			For State Registrar	State of Maryl		artment of rtificate of		ind Ment		ene 20	05	01129
	Physicia /Medic Examin	al .	1. Decedent's Name (First, Middle, Las	street and number)	N		n, or Location o	JAN f Death	ate of Death Jonth UARY	Day 200	of Death	3. Time of Death 9:45p M
	Funeral Director		3226 BELLMONT AV 5. Social Security Number 6. Security Number 11 Usual Residence of Decedent	7. Age (In	yrs. last birthday) 86 Yrs.	If Under 1 Ye Months Da			ate of Birth fonth, Day,) -18-19			lace (State or Foreign try) A•
	the Maryland 28a-f show	rector	10a. State 10b. County MD • N/A 10e. Street and Number	100	. City, Town or Lo		le		100	J. Citizen of W		0d. Inside City Limits 1 Yes 2 No
000	permit. Pages 1 and 2 should be lied within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Importent: If than 27 is marked othat than "netural", or Itama 23a or 28a-f show any injury or other traumatic event, the Modical Examination collified at once.	by Funeral Director	3226 BELLMONT AT 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	JE • 12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		212 Was Decedent of the Yes, specify C	216 of Hispanic Orig Cuban, Mexican	gin? (Specify Y , Puerto Rican		USA 14. Race Black		an Indian, etc.
N-01717	illed within 72 hou Hygiene. thar than "neture int, the Medical E	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12) -7 - 17. Father's Name (First, Middle, Last)	cation fe completed) College (1-4or 5+) -0-	(Give	dent's Usual Oc kind of work do DO NOT use re JSEKEEPI	ne during most tired)	of working			STIC	
VIai yiaii	d 2 should be f th and Mental h 7 is marked of traumatic eve	To Be	HARRY CARTER 19a. Informant's Name/Relationship (7 CARROLL CAMPBEL)			ng Address (Str.	GERT	RUDE P	AYNE te Number, (City or Town, S	State, Zip	
baltillore, i	permit. Pages 1 and 2 Department of Health Importent: If Itam 27 any injury or other tru once.		20a. Method of Disposition 1 Purial 2 Crimation 3 4 Donation 5 Other (Specify 21. Signature of Emeral Service Licen	Removal from State	Db. Place of Dispo cemetery, cree	osition (Name of matory or other ORIAL PA	place) ARK 1-	Date -22-200	5 E	Oc. Location - (City or To	wn, State
Da	permi Depa impo any ir		23a. Part Enter the disease, or composhock or heart failure. List only of	lications that caused the	ا ا	.@!_@& N	. MONRO	DE ST.	BALTIN	MORE, M	•	AND 21217 Approximate Interval Between Onset and Death
,007	Physician / Medical special physician and physician and physician and the prival-transit the prival-transit special physician and physician an	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Da	ecu +	Delit	ener	ta	,		yes yvs.
.O. DOX 0	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pri 1 ☐ Live birth 2 ☐: 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregna ⊒ Other (specify				23d. Date Mon		ry Day Year
cords, r	The law requires that the ste has been signed by th page 2 should be detache	by	Part II. Out or fignificant conditions of	ontributing to death but pol	t resulting in the u	inderlying cause	given in Part I.		1 🗆 Yes	2 N 0	3 ☐ Prob	e cause of death?
	The la	Be Completed	25. Was case referred to medical				26. Place			ed?	rior to cor eath?	osy findings available inpletion of cause of
5	Attending Physician: r death. ector: After this certific. by the funeral director,	၉	examiner? 1 Yes 2 ZNO 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time o	of 28c. I	Other: 4 Null njury at Work? 1 Yes 2 1			ce 6 Othe		')
DIVIS	To the Hospitel or Attendi within 24 hours after death. To tha Funaral Director: A completely filled in by the fu	i Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sc	pecify)			С	ity or Town,	State)		Route Number,
	To the Hos within 24 ho To the Fun completely	Medical	(Check only 2 Medical Exemone) 20b. Signature and the of certifier	iner: On the basis of examination and manner stated.	mination and/or in	ivestigation, in m	ense number	h occurred at t	the time, date	e and place, a	nd due to	the cause(s)
	6		30. Nam and address of person who of DR • ECKENRO		(Item 23a) (Type, MONDS RI		E L2 BAT	06 Z LTIMORE	MARY	///	11	25
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 0 2005	Pagistraria S	ignature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** RICHARD KEIM JANUAKU /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltinore Vorthwest 405pital andalls town (enter If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 01/09/ 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F Months MARYLAND 58 **Director** 214-44-6376 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23a or 28e-f show the Medical Examiner must be notified at Director XXves 2 □ No MD BALTIMORE CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3543 ELMLEY **AVENUE** 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1. ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1

Never Married 2

Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12TH YEARS STORE OWNER SELF-EMPLOYED marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental H UNKNOWN MARGARET NEALLIE ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 soft Health and tem 27 is CHERYL PRATT / CAREGIVER 3818 JANBROOK RD, RANDALLSTOWN, MD 21133 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 01/20/05 METRO CREMATORY CATONSVILLE, MD ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HGHTS AV, BALTIMORE, Enter the disease, or complications that posed the read ailure. List only one cause of the line. sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disea or condition resulting in death) 520818 **Physician** /Medical Due to (or as a consequence of): Examiner Muniona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discuss or injury) iner Due to (or as a consequence of) death certificate be executed use as the burial-transi Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be d Completed by Failus 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 certificate 1 Tes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 1 Inpatient 2 ER/Outpatient 3□ DOA completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. P Division of Vital Records, or Attending Physicien: after death Director:

To the Hospitel

within 24 hours a To the Funerel C State

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of

29a Certifier

d cause of death (Item 23a) (Type, Print) IMPERIM 32. Reg

2005

and manner stated.

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

RANDALLSTOWN 5401 OLD COURT RD,

			1 10030 1	State of Mary	land /	Depa	rtment of H	lealth a	nd Men	tal Hygie	ene	
		•	For State Registrar			Cert	tificate of l	Death		Reg	. No. 2005	01131
	Physicia		1. Decedent's Name (First, Middle, Last)							Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Nellie Krat:				4h Cib. Tours o	- Logation o		ın. 18,	2005 4c. County of Dea	11:40 A M
	Examin	er	4a. Facility Name (If not institution, give s Cross Keys Road				4b. City, Town, or Baltin				N/A	201
	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last l	birthday)	If Under 1 Year Months Days		24 Hrs. 8.1	Date of Birth Month, Day, Y		rthplace (State or Foreign ountry)
	Director		217-09-5987]M 2 K]F	87	Yrs.	Months Days	Hours		v. 11,	1917	Maryland
	and	}	Usual Residence of Decedent 10a. State 10b. County	100	c. City, To	wn or Loc	ation					10d. Inside City Limits
	Maryi -f sho	to	Md. N/A			Bal	timore C	City				1 XYes 2 No
	ter death with the Marylan Itams 23a or 28a-f show It et mark by notified at	Funeral Director	10e. Street and Number				10f. Zip Code			100	g. Citizen of What C	country?
	ath wi	rai		Apt. 115C		1.0.11		210	1-0 (0	V N-	USA 14. Race - Am	origan ladian
	itams	une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2\ No	in U.S.	13. V	/as Decedent of H Yes, specify Cuba	an, Mexican	, Puerto Rica	in, etc.)	Black, Wh	
036	72 hours after death with the Maryland natural; or itams 23a or 28a-f show iteal Evantiar mart by notified at	þ	3 XWidowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2【XNo	Specify:			Specify:	White
21215-0036	I within 72 hours after iene. iene. r than "natural", or itt	Completed	15. Decedent's Edu (Specify only highest grade		16	(Give k	ent's Usual Occup	during most	of working	16	6b. Kind of Busines	s/Industry
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d 2	Hyg Hyg the ont,	a	17. Father's Name (First, Middle, Last)			Admiri	11301001				aiden Sumame)	, α Ι
'lan	o d ta	To B	Harry Car	ter					Eller	Wils	on	
Maryland	d 2 should th and Mer 7 is marke traumatic	5	19a. Informant's Name/Relationship (Ty		1	· ·					City or Town, State,	
	1 and 1 eall and 2 em 2 thar		Mr. John E. Kratz,		0b. Place	of Dispos	orthfield sition (Name of	1	e Bal		, Marylar Dc. Location · City o	
Baltimore,	8 5 = 0		1 Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)			-	atory`or other plac 'k Cemete		/22/0	. Ra	ltimore,	Varyland
altir	2 P P P		21. Signature of Funeral Service Licens		oude	22.	Name and Addre	ss of Facilit	Ruck	Towson	Funeral	Home, Inc.
ä	Depar Depar impoi any ir		mulad	Ruch		10	50 York	Road	Tows	n, Mar	yland 212	204
Г			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the ne cause on each line.	death. D				cardiac or re	spiratory arres	st,	Approximate Interval Between Onget and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	PUlm	Char	-	ibrosi:	\$				10 415
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	7 -	ner	if any, leading to immediate	Due to (or as a co	nsequen	ce of):						
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Вох	leath certifica attending ph I for use as ti	an/M	23b. Was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐			Ectopic pregnanc	y			23d. Date of d Month	elivery Day Year
.O.	ie dea the at hed fo	Physician/Med	in the past 12 months? 1 □ Yes 2 ■No 9 □ Unknown	4☐ Pregnant at time 9☐ Unknown	e of death	າ 5□	Other (specify) _					,
Δ.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it		Part II. Other significant conditions co	ntributing to death but ne	ot resultin	ig in the ur	nderlying cause giv	ven in Part I		23e. Did toba	cco use contribute	to the cause of death?
Records,	quires that in signed build be det	ed by	Dementia q	Alzherm	×'5	phb	e			1 ☐ Yes	2 No 3□I	Probably 4 Unknown
900	e law requir has been si ge 2 should	plet	Prednisone	(chronic)	USP					24a. Was an autopsy	prior to	autopsy findings available completion of cause of
R		Completed								perform 1 Yes 2	ed? death?	
Vital	Physician: this certificantili	Be	25. Was case referred to medical examiner?	Hospital:	• 🗆 🖘	10	Ott	205		heck only one) nce 6 □Othe <i>r (Sp</i>	agaifu)
of		7: 70	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye		Outpatien b. Time of Injury			-		v injury occurred	ocny)
ion	Attanding Firdeath. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation		rai)	ilijuly		Yes 2				_
Division	or Atta ter de irecto n by th	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	- At home Specify)	, farm, str	eet, factory, office		28f.	Location (Stre City or Town,		Rural Route Number,
	pital o		29a. Certifier 1 Certifying Phy	vsician: To the best of m	ny knowle	dge, death	occurred at the ti	me, date ar	nd place, and	due to the car	use(s) and manner	as stated.
	To the Hospital or Attand within 24 hours effer death To the Funaral Director: completely filled in by the	edical	(Check only 2 Medical Exam	iner: On the basis of ex and manner stated	amination	and/or inv	vestigation, in my	opinion, dea	ath occurred	at the time, dat	te and place, and d	ue to the cause(s)
	To th withir To th	M	29b. Signature and title of certifler	Work.			29c. Licen	se number	4.	29	d. Date signed (Mo.	nth, Day, Year)
	/		mek	NONE	44-		Du	1729	U		111910) 21092
	h			pmpleted cause of death	n (Item 23	Ba) (Type,	Falls P	000	Sule	200	Lotha	will mo
	St	ate	31. Date filed (Month, Day, Year)	32. Redistrar's	Signature	8	bode					V
	Regist		JAN 2 0 2	005	J 1	1 4	200					

_			1 - For State Registrar	State of Man			of Health <i>of Deati</i>			giene 2 (05	01132
	Physici /Medic Examir	cal	4a. Facility Name (If not institution, a	(LIONSKF		4b City To	wn, or Location		2. Date of De Month JANUAR	7 16	Year 2005	3. Time of Death 3:20 7 M
	Funeral	ier	NORTHWEST HO	SPITAL CE	In yrs. last birthday	RAI	NDALL Year If Unde	STO or 24 Hrs.		13	ALTIC	noRE :
	Director		Usual Residence of Decedent	1□ M 200 F	73 Yrs.	Months D	Days Hours		8. Date of Bird MAR. 12	, 1931	Count	ZLARUS
	the Marylar 28a-f show	ctor	10a. State 10b. County MD BALT		0c. City, Town or L BAL 7	ocation FIMORE					100	d. Inside City Limits
	th with th	al Dire	10e. Street and Number 7920 SCOTTS LE	/EL ROAD		10f. Zip Co	ode 212	208		10g. Citizen of	What Countr	^{y?} USA
960	iges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other then "natural", or Items 23a or 28a-f show or other traumatic event, the Modical Exantret must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 💢 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 X No If Yes, Give Year or Dates:		Was Deceden If Yes, specify 1 ☐ Yes 2 ☒			ecify Yes or No- Rican, etc.)	14. Ra Bla Specia	ce - American tck, White, et fy:	
21215-0036	ed within 72 h giene. ar than "natu , the Wedical	Completed	15. Decedent's E (Specify only highest g	Education rade completed) College (1-4or 5+) 5+	(Give	DO NOT use r	done durina ma	st of work	ing	16b. Kind of E		stry
Maryland	2 should be filed within and Mental Hygiene. Is marked othar than aumatic event, the Mental Head.	To Be (17. Father's Name (First, Middle, Las ISAAC	t)	KLI	NSKY	18. Moti		e (First, Middle,	Maiden Sumai	GOLD	DINA
	and 2 should leath and Men n 27 la marke lar traumatic	ľ	19a. Informant's Name/Relationship MARK TSITLIK /						REISTE			
Baltimore,	Pages 1 a nent of He int: If itam iry or otha		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	20b. Place of Dispo cemetery, cre BALTIMORE	matory or othe	r place)		7 / 2005	20c. Location	- City or Tow	
Balti	permit. Pages 1 and 2. Department of Health a Important: If itam 27 la any injury or othar trau		21. Signature of Funeral Service Lice		2:	2. Name and A	Address of Faci	lity SO	L LEVIN	SON & B	ROS.,	
S STATE	Priysician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	death. Do not en	ter the mode of					A Ir	Approximate hterval Between Onset and Death
8760,	eate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causes (2 leaded or in july that initiated events resulting in death) Last	b. Due to (or as a co								
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	∃Ectopic pregn] Other (s <i>pecif</i>					te of delivery onth Da	ay Year
	quires that n signed t uld be det		Part II. Other significant conditions			nderlying caus	e given in Part	l.		bacco use cont es 2 □ No	tribute to the	cause of death?
Vital Records,		Completed by							24a. Was a autop: perfor 1 \(\text{Yes} \)	sy med?	prior to comp death?	y findings available letion of cause of
of	Phys ral di	lon; To Be	25. Was case referred to medical examiner? 1 Yes 2 Vo 27. Manger of Death 1 Natural 5 Pending	Hospital: 1 Impatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatier 28b. Time of Injury	f 28c.	Cther: 4 N Injury at Work?	ursing Ho	n (Check only or me 5 Residence 1986). Describe he	ence 6 Oth		
Division	or Atten fter deat Sirector: in by the	Certification;	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	09 Place of Injury	At home, farm, str Specify)	M eet, factory, off	1 ☐ Yes 2 ☐		28f. Location (Si City or Town	treet and Numb n, State)	er or Rural R	loute Number,
	To the Hospital within 24 hours a To the Funaral Completely filled	Medical C	29a. Certifier (Check only one) (Check only one)	nysician: To the best of m miner: On the basis of exa and manner stated	amination and/or in	n occurred at the	he time, date al my opinion, de	nd place, a	and due to the c	ause(s) and ma ate and place,	inner as state and due to th	ed. e cause(s)
)	To the within To the comple	Me	29b. Signature and atte of certifier	9475161	1	29c. Lic	cense number	123	JA	9d. Date signer	d (Month, Da	2005
_	17		30. Name a Tres Joseph who	completed cause of death	(Item 23a) (Type, HA RIS	Print) NO	RTH W	OLD	COURT	ROAD	3	ERTER. D 21133
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2	32. Registrar's	Signature	A TONE	A. J.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year UAZ MARIAN KRAMER 17 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | JANN-11.5, 1923 BALTIMOR NORTHWEST 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F 82 219-18-9763 Director Yrs. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rei', or items 23a or 28a-f show Examiner and be notified at Completed by Funeral Director 1 ☐ Yes 2 👿 No BALTIMORE RANDALLSTOWN MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3702 BROWNBROOK COURT 21133 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced "naturei", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANAGER STATE OF MARYLAND 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Heelth and Mental H ant: If item 27 is marked ott Be KRAMER JENNIE MINNER MORRIS ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Heelth ar important: if item 27 is any injury or other trau once. 35 STONEHENGE CIRCLE #9 - BALTIMORE, MD 21208 KAY GREEN / NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) (ANSHE EMUNAH)AITZ CHAIM 1/18/05 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Tocas 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCLEPOTIC CARDIOVASCULAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of ding physicien and ise as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2/No 1 ☐ Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Tes 3/1 No 2 ER Outpatient 2 1 Inpatient 3□ DOA After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 Yes 2 No Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerei Direct completely filled in by filled in by 4 / Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

IR ITH

30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

5401

32. Registrar's Signature

JOSEP

Registrar DHMH 17 Rev 1/2001

State

OUD

29c. License number

29d. Date signed (Month, Day, Year)

RANDAUSTOWN

Jan 17, 2005

23a or 28a-f show 72 hours after death or Items Maryland 21215-0036 "natural", permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any jury or other traumatic event 9008. Baltimore,

Physician

/Medical

Examiner

10a. State

Funeral

Director

other traumatic event, the Madical Examiner roust be notified at

Completed by Funeral Director

Be ပ

Physician /Medical **Examiner**

Physician/Medical Examine Completed by Be 2 Certification:

physician and the burial-transit After thi funeral of death. Director: within 24 hours after To the Funeral Dire

the Hospital or Attending Physician: The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

10e. Street and Number 725 Milldam Road 11. Marital Status 1 ☐ Yes 2√XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3. Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner/Operator 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Paul Costakis Helen Burnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Mary Lou Angelaras/Daughter 725 Milldam Road Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1

Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 1/21/05 Greek Orthodox Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASPIRATION Pneumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy 5 Other (specify) 9 Unknown Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. insu forciency 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manper of Death 1 🗹 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier

20c. Location - City or Town, State Baltimore, Maryland

Ruck Towson Funeral Home, Inc.

Towson, Maryland 21204 Approximate Interval Between Onset and Death

16b. Kind of Business/Industry

Hotel

3 weeks

White

23d. Date of delivery Day

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2□ No 2 No 1 Yes

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D50760

or 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LuTherille, mp 21093

307.

State Registrar 1407

YORK Rd

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) Year **Physician** January 17, Peter Paul Lochary 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1XM 2□F Months Days Hours Yrs. Director 218-09-1683 87 1917 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 1 ☐ Yes 2 No Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 1710 M Landmark Drive 21050 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race · American Indian, Black, White, etc. 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: other traumatic event, the Madical Example of Specify: 3 X Widowed 4 ☐ Divorced White natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) State of Maryland Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Park Service 11 Forest Warden 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be and Mental 2 Wilson Lochary Mary Roberta Harkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Department of Health a Important: If item 27 Is any injury or other traconce. Jeannie Lochary – Daughter 1445 Sharon Acres Road, Forest Hill, MD 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location · City or Town, State tX Burial 2 ☐ Cremation 3 ☐ Removal from State *4 □ Donation 5 □ Other (Specify) Bel Air, Maryland Bel Air Mem. Gardens 1/20/05 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to intrinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death cartificate be exacuted attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 Yes 2 No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 \(\subseteq \text{Yes} \) 2 \(\subseteq \text{No} \) certificate has 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of hirry (Month, ay Year) Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending Injury 5 Pending Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

Registrar

State

May #102 Edgewood 21048

		Please Ty Amend item#22, perFH 1 - State Registrar	Julio of Marylan		ate of L		wichtal 11	Reg. No.) A O C	0113
Physic /Medi		1. Decedent's Name (First, Middle, Last) Gilbert Owen	Mcleod				2. Date of D Month	eath Day	Year 2005	3. Time of Death
Examir Funeral	er	4a. Facility Name (If not institution, give str Bolfmore VA Medica 5. Social Security Number 6. Sex	Center 7. Age (In yrs.	last birthday) If U	altimos nder 1 Year	Location of Deat If Under 24 Hrs Hours Min.		irth	9. Birth	place (State or Forei
irector		2 8 · 48 · 259 100 Usual Residence of Decedent 10a. State 10b. County	1 2 □ F	y, Town or Location		110013	D2.19	3.1950	>	MD
a or 28a-f show	ector	MD N/A	Tot. Cit	Baltin				10- 01-		10d. Inside City Lim. 1583es 2□1
23a or	Funeral Director	2109 Homewood	Avenue	ioi	Zip Code	218		Tog. Citize	of What Cou	ntry ?
rel', or Items 23a Examinat must t	by	11. Marital Status 12 1 💢 Never Married 2 🗆 Married 3 🗆 Widowed 4 🗀 Divorced	. Was Decedent Ever in U. Armed Forces? 1-∰Yes 2 ☐ No If Yes, Give Year or Dates:		ecedent of Hi specify Cuba s 2⊠No	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or N to Rican, etc.)		Race - Ameri Black, White pecify:	
r then "naturel",	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	tion completed) College (1-4or 5+)		f work done a T use retired,	ition uring most of wo	rking		of Business/Ir	
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and mental hygiene. Is marked other then aumatic event, the Ma	ဥ	JOHN C. McLeo C 19a. Informant's Name/Relationship (Type		19b. Mailing Add	ress (Street a		CA Da Iral Route Numi		own, State, Zij	Code)
12 Tr		Beverly M. Woolfor			yram	120ad 7	3altim		ID 212	39
rtment o rtant: If njury or		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Rer '4 □ Donation 5 □ Other (Specify)	noval from State	Place of Disposition emetery, crematory	or other place Forest	DIZ	Date 24. DS	DW	inas N	lills, MD
Impo any ir once		21. Signature of Fune all ervice License		22. Nam Vou 5151	e and Addres	s of Facility Oreen	e Funer	al sen	Himne.	21229 MD-24
physician and strength aminer strength aminer.	dical Examiner	23a. Part1. Enter the disease, or complica shock, or heart illure. List only one timediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. d.	Hepatic Due to (or as a consequence)	Encephanuence on: 5tage Luence on: of Abus	1 .					Intervat Between Onset and Death
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sign d be	by	Part II. Other significant conditions contri	buting to death but not resu	ulting in the underlyi	ng cause give	n in Part I.		tobacco use	/	he cause of death?
cate has been page 2 shoul	Completed						24a. Was auto perf 1 Yes		4b. Were auto prior to co death? 1 Yes	opsy findings availal impletion of cause of
is certificate director, pag	o Be	25. Was case referred to medical examiner?	pital: 1 npatient 2 🗆	ER/Outpatient 3	Dithe Dithe	26. Place of Dea	ath (Check only		10shay /0	
fter th	H .	27. Manner of Death 1 Vatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury Work	Armed and a second	28d. Describe			y)
within 24 hours after user To the Funerel Director; completely filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of tnjury - At ho building, etc. (Specify	ome, farm, street, fac	ctory, office		28f. Location City or To	(Street and Nown, State)	lumber or Rura	al Route Number.
Funer ely fille	ledical (29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	ian: To the best of my known: On the basis of examinate and manner stated.	wledge, death occur tion and/or investiga	red at the tim tion, in my op	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) an date and pla	d manner as s ace, and due to	tated. the cause(s)
9 9	Ž.	29b. Signature and title of certifier	4.4		29c. License			29d. Date s	igned (Month,	Day, Year)
To the complete		111								
within 24 hours after death. To the Funerel Director: A completely filled in by the fu		30. Name and address of person who com	Mil).	23a) (Time Brief)	AM255	6996M14	15	1/15	1/200)

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	Registrar 1. Decedent's Name (First, Middle, Las.	()	Ochincate of Dea	2. Date of De	Reg. No.
Physician	EILA N	TICITELL		Month	Day Year
/Medical	4		4b. City, Town, or Locati	ion of Death	4 17 2005 4 45A M
Examine	GENESIS ELDER	_	MANNE BALTIMO		Baltimore
Funeral Director	5. Social Security Number 6. Se 238 · 38 · 9284	7. Age (In yrs. las		der 24 Hrs. 8. Date of Bird	h 9. Birthplace (State or Foreign Country)
pug *	Usuel Residence of Decedent 10a. State 10b. County	10c City 7	own or Location		10d. Inside City Limits
d 21215-0036 filed within the Maryland Hygiene. They have after death with the Maryland Hygiene. They have not they have not the Maryland and they have a few and the Maryland Examinar must be notified at a Completed by Funeral Director.		A	Baltimor	e	1 XYes 2 No
Site death with the Mar utter death with the Mar in thems 23e or 28a-1 el in the must be notified funeral Director	10e. Street and Number 27 N. Cillver	Street	10f. Zip Code 212		10g. Citizen of What Country? US.A.
36 36 s after de		12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	13. Was Decedent of Hispanic If Yes, specify Cuban, Mex		14. Race - American Indian, Black, White, etc.
5-003(72 hours a matural), collect Even	3 XWidowed 4 □ Divorced 15. Decedent's Edi (Specify only highest grac	Year or Dates:	6a. Decedent's Usual Occupation	-	16b. Kind of Business/Industry
laryland 21215-00 2 should be filed within 72 hou and Mental Hygiene is marked other than "naturu aumaits event, the Medical Education To Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 2 Years	(Give kind of work done during relife. DO NOT use retired) Electrical Te	chnician	Private
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Via build the Ment Ment arked attic	Charle Pern			Ada Whit	
Baltimore, Maryland 21215-0036 Sentimore, Maryland 21215-0036 Sentil: Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene Important: If them 27 is marked other than "natural; or items 23e or 28a-1 ehow my highly or other fraumatic event, the Medical Examinar must be notified at 2008. To Be Completed by Funeral Director	/ / /	aughter !		ad Baltin	r, City or Town, State, Zip Code) Note MD 21207
Baltimore, N permit. Pages 1 and. Department of Health Important: If item 27 and injury or other it	20àMethod of Disposition 1 (⊠Burial 2 □ Cremation 3 □ F 1 4 □ Donation 5 □ Other (Specify,	Removal from State	e of Disposition (Name of Jetery, crematory or other place) WNSVIIIE VA	Date D1. 24.05	20c. Location - City or Town, State CITWISVILLE, MD
Balti permit. Departm importa	21. Signature of Fulieral Service Licens				VICO Pike Baltimoreno 21229
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death. I	Do not enter the mode of dying, such	as cardiac or respiratory ar	rest. Approximate
Physician	Immediate Cause (Final disease or condition		ENAL SYNE		Interval Between Onset and Death
/Medical Examiner	resulting in death)	Due to (or as a consequen	ce of):		10 2043
	Sequentially list conditions, in the cause. Enter Underlying Cause, Disease or injury	b. Due to for as a consequen	OF COLON.		FEW MONRA
executed in and inal-transit	cause. Enter Underlying Cause (Disease or injury that initiated events	с.			
S 69 50		Due to (or as a consequen	ce of):		
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Division of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certificateler clearh. In the time relations on titicate has been signed by the attending phin by the tuneral director, page 2 should be detached for use as the relatification: To Be Completed by Physician/Median	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
that the ted by detacl	Part II. Other significant conditions co	ntributing to death but not resulting	g in the underlying cause given in Pa	art I. 23e. Did to	bacco use contribute to the cause of death?
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Division ce tale or Attending Person after death. The after death by the funer in	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)			treet and Number or Rural Route Number, n, State)
Hospita 4 hours Funeral ely filled	29a. Certifier 1 Certifying Phy (Check only Medical Exemi	ner: On the basis of examination	dge, death occurred at the time, date and/or investigation, in my opinion, i	and place, and due to the death occurred at the time.	ause(s) and manner as stated. ate and place, and due to the cause(s)
To the within 2 To the complete	one) 29b. Signature and title of certifier	and manner stated.	29c. License numbe		19d. Date signed (Month, Day, Year)
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	30. Name and address erson who co		a) (Type, Print)	7+7	TANUARY IT 200T TIMORE MD 2129
4	A SECTION A MALE	0-7	WILKENS AV	ENUE BAN	TIMORE MD 2125
State Registrar	31. Date filed (Month, Day, Year)	32. Resistar's Signature			Ò

DHMH 17 Rev 1/2001

ORIGINAL

Darrell McClary Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. unpenditem#23a.27.perMF. G842.4-1-05 TT State of Maryland / Department of Health and Mental Hygiene 1 1 5 05-00389 crn 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death January 16, 2005 **Physician** MCCLARY 5:00 РМ DARRELL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months, Days Hours Min. (Month, Day C.T. 27 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Months 1**⊠**M 2□F 219-67-861 Yrs Director Usual Residence of Decedent the Maryland 10b County 10d. Inside City Limits 10a State 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 5 56 AYETTE AVENUE Items 23a 45A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2/0 No 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ont: If item 27 is markad other than "netural", or Iter 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify If Yes, Give Year or Dates: Completed by BLAC 3 Widowed 4 Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DARRELL ೨ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Importent: If item 27 Is any injury or other train <u>once.</u> 2569 W. LAFAYETTE AVE. DENICA PARKER MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State MT. ZION CEME (GABYLAND) 01-22-05 * 4 ☐ Donation 5 ☐ Other (Specify) LANSDOWNE MARYLAND 22. Name and A gress of Facility BROWN JR. FUNERAL HEME 21. Signature of Funeral Service Licenses · FULTON AVE. BALTO, MD. 2121 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Acute Leptomenigitis and encephalitis /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physicien Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Loknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ► Yes 2 □ No 24a Wasan autopsy performed? 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1∰ Yes 2 □ No Hospital: 14 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this

Division of Vital Records. Hospital or Attending

After t

Director:

death.

Certification:

within 24 hours a To the Funeral C Medical State 27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

29a. Certifier

5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

111 Penn Street, Baltimore, Maryland 21201

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certified

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

January 17, 2005

MEDDORE MIKE 31. Date filed (Month, Day, Year) JAN 2 0

2005

herbe l

egistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:18 M 05 MARINO, 01 18) Ames /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner upperchesapeake medical HARFORD Centen BelAIR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 150M 2□F 171-01-8271 00 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No BALTIMORE ROSEDALE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6311 FIELDVALE ROAD 21237 U.S.A. death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ Yo If Yes, Give filed within 72 hours after 1 Never Married 2 Married 'natural', or 1 ☐ Yes 2 No WHITE Specify: Completed by 3 ₩ Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry od other than "nature ovent, the Madical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SUPERINTENDENT BETHLEHEM STEEL 6 and Mental Hygi 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be DANIEL MARINO (GERMANIA) IDA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1223 ST. FRANCIS ROAD JOHN MARINO/SON permit. Pages 1 and 2. Department of Health a Important: If Item 27 is any injury or other trau BEL AIR, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ` 4 □Donation 5 Other (Specify) FNDMBMENT PARKWOOD CEMETERY 1-22-05 PARKVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME ROSEDALE, MD 1211 CHESACO AVENUE NI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COROWANY /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 5 Other (specify) 4☐Pregnant at time of death P.0. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ Unknown 1 🗌 Yes 2 🗌 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 Yes Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be James Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) **ER/Outpatient** 3 No 1 Yes 3□ DOA Medical Certification: To 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death After Injury 5 Pending 1 Yes 2 No death. investigation completely filled in by the ☐ Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 0 within 24 hours a To the Funeral I Sertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie P0036487 and apper Ches Apente Medical Center 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

gistrar's Signature

			1 - For State Registrar	State of Mary		artment of H		-	giene Reg. N2 0	05	0111	٠, ١
	Physici		Decedent's Name (First, Middle, Last James M	η cNair, Jr.				2. Date of De Month	ath	O S S	3. Time of De 8:30p.	
	/Medic Examin		4a. Fecility Name (If not institution, give Future Care H	omewwod		4b. City, Town, or Balti	imore		4c. County			
	Funeral Director		5. Social Security Number 218-62-3949 Usual Residence of Decedent	9X 7. Age (Ir M 2□ F 49	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	lin. (Month, Da	th y, Yeer) 9 1955	Cou	place (State or F ntry) ID	'orei g n
	deeth with the Maryland ms 23a or 28a-f show	tor	10a. State 10b. County MD N/.		c. City, Town or Lo Baltin						10d. Inside City I	
	with the	i Director	10e. Street and Number 2130 N. Wolfe S	treet		10f. Zip Code 212	213		10g. Citizen of V	What Cou	ntry?	
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and 21	be filed ntal Hyg td other event.	Be	12th 17. Father's Name (First, Middle, Last)	N/A	Sel	f employe	18. Mother's h	Name (First, Middle,		ne)		
Maryi	s 1 end 2 should I Heelth and Men Item 27 is marka other treumatic	오	19a. Informant's Name/Relationship (7	** * *			and Number or	ristine Rural Route Number	-	State, Zip	o Code)	
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Vital H	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital:	2 ER/Outpatier	it 3□ DOA Othe	/	Death (Check only of Besiden Street)		er (Speci	(v)	
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Division	P Sire	O	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	At home, farm, str Specify)	eet, factory, office		28f. Location (3 City or Tox	Street and Numb vn, State)	er or Rura	al Route Number	r,
	To the Hospital or within 24 hours efter To the Funeret Dir completely filled in	ledical	29a. Certifier Check only one) Certifying Ph	ysicien: To the best of mainer: On the basis of example and manner stated	amination and/or in-	n occurred at the tim vestigation, in my op	ne, date and pla pinion, death of	ace, and due to the ccurred at the time,	cause(s) and ma date and place,	inner as s and due t	stated. o the cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifie	1,	Min	29c. License			29d. Date signed			
	211		30. Name and address of person with	MULLITA	(Item 23a) (Type,	(838)	- 6	sen en	1100	Rel	2/20	is a
	Sta Registr		31. Date filed (Month Day, Year)	32. Registrar's		house o			1.44			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 2:30 AM GERALD ELI NAIMAN 2005 /Medical anuary 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balling Hours Min. 12 /13 /13 Hos ita Baltimore N/A 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Yrs. 12/13/1927 Director 123-22-3497 Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 is markad other than "naturat", or items 23a or 28a-f show traumatic event, the Medical Exam an must be notified at MD N/A BALTIMORE 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3818 MENLO DRIVE 21215 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Agreed Forces? 1 ⚠ Yes 2 □ No ARMY If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE 3 ☐ Widowed 4 ☐ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) SALESMAN WHOLESALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should ba fit ment of Health and Mental H tant: If item 27 Is markad otl Be DAVID NAIMAN FANNIE CHOMSKY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3818 MENLO DRIVE BALTIMORE, MD 21215 DEBORAH NAIMAN / WIFE other 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ö permit. Page Department of Important: If any injury or once. CHOFETZ CHAIM CONG. 01/18/2005 ROSEDALE, MD * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MUP months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours after death.

To the Funeral Diractor: After this cardificate has been expected. burial-transit resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Completed by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 2 No 2 A No 1 Yes Division of Vital 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 🗷 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 18,)anuary O, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai 31. Date filed (Month, Day, Year) 32. Registrar Signature State

DHMH 17 Rev 1/2001

Registrar

JAN 2 0

Naiman, Gerald

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5

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_				tate of Maryland As per Dr., G8	9 01/20/05dhl Certificate of t			2005	01143
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	Sta Registi		JAN 2 0 2005	32. Registrar's Signature	pole				

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15x		Marjorie Dannis, M.D.		George		ad, Bethe	sda, M	ary1a	nd 2081	.7
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			For	State of Marylan				Mental Hy	giene) A P	
			State Registrar 1. Decedent's Name (First, Middle, Last,		Ce	rtificate of	Death	2. Date of De	Reg. No.	105	3. Time of Death
	Physicia		ISADORE			NEU	MAN	JAN.	15	2005	8:20 A M
	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Death	1	4c. Cour	nty of Death	
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	Funeral Director		5. Social Security Number 6. Se 12 6. Se 12	7. Age (In yrs.	Yrs.	Months Days	Hours Min.	8. Date of Bir 04/04/	1924)	Count	ace (State or Foreign try) MD
	D.		Usual Residence of Decedent 10a, State 10b, County	100 Cit	y, Town or Lo	noation				10	Od. Inside City Limits
	death with the Maryland sms 23a or 28e-f ehow ir must be nutified at	ō	MD BALTIN			ERVILLE				10	1 ☐ Yes 2 ☑ No
	r 28e-	Director	10e. Street and Number	TOTAL	LOTT	10f. Zip Code			10g. Citizen o	of What Count	
	th with		1601 BROADWAY ROA	ADD			21093	:			USA
	er dea	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	14. R	ace - America lack, White, e	
030	be filed within 72 hours after death with the Marylan tal Hygiene. d other than "natural", or liems 23a or 28e-1 show event, I're Madical Evantiner mast be nutified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🂢 Divorced	1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Spec	cify:	WHITE
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ylan		To B	LOUIS		NEWM	AN	FAYE			GOTT	LIEB
Mar	s 1 and 2 should f Health and Men item 27 is marke othar treumatic		19a. Informant's Name/Relationship (7)	урө, Print) JGHTER		ng Address (Street BROADWAY			•		
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	Physician /Medical		disease or condition resulting in death)	a CELEBROVA Due to (or as a conseq		a Acci	DENT				
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	ed isit	lner	Sequentially list conditions, if any, leading to immediate cause. Finer Inderhing Cause (Disease or injury	Due to (or as a conseq	juence of):						
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X Q Q	death certificate e attending phys id for use as the	Physician/Med	in the past 12 months?	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	I death 3	☐Ectopic pregnanc ☐ Other (specify) _	у			Date of delive Month	ry Day Year
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Vital		e Co	25. Was case referred to medical				26. Place of Dea	1 Yes	2 12 No	1 🗆 Yes	2 No
	Physician: r this certific ral director,	To B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA Oth	-	lome 5 Resi		Other (Specify	"
n of	ding Ph h. After th funeral		27. Manner of Death 1 DNatural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ry at rk?	28d. Describe			
Division	death.	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury · At h	ome, farm, st		Yes 2 □No	28f. Location /	Street and Nu	mber or Rurai	I Route Number,
2	tal or Attandii s after death. al Diractor: A ed in by the fu	Certification;	4 Homicide determined	building, etc. (Special	fy)	100tj 120t01y 011100			wn, State)		
	To the Hospital or Attanding Pl within 24 hours after death. To the Funeral Diractor: After It completely filled in by the funera	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, dea ation and/or in	th occurred at the ti	me, date and place opinion, death occu	a, and due to the urred at the time,	cause(s) and date and plac	manner as sta e, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens			29d. Date sig		
	1		> cunquesson	ie MO		DI	6619		Vania	my 17	, 2005
	9		30. Name and address of person who of C .V ERGARA - SOF	ompleted cause of death (Iter	п 23a) (Туре 56м/л.	Print) ANY AVE	LUTHER		,	,	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature						
	Regist		JAN 2 0 2	005 /	A	Soules -					
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O5-00033 Folake Olagundoye

Please Type or Print în Black Indelible Ink. Ensure All Copies Are Legible.

Physic		1. Decedent's Name (First, Middle, I	Last)				2. Date of Dea			3. Time of Death
		01awunmi		oye			January	02,	2005	01:11 Ам
/Medi Examii		4a. Facility Name (If not institution, g Doctors Communit	give street and number)		4b. City, Town, C Lanham	or Location of Death	1		ty of Death	orge's
Funeral Director		610-90-2983	.Sex 7.Ag 1 ☐ M 2 🔀 F	ge (In yrs. last birthday 30 Yrs.) If Under 1 Year Months Days		8. Date of Birth (Month, Day Jan 24,	Year) 1974	9. Birthp Cour Nige	place (State or Foreign ntry) :ria
Mo Ta		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				1	0d. Inside City Limits
e-tsh	ctor	MD Prince	Georges	New (Carrollto	n				1 ₁ Yes 2□No
or 28	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of		ntry?
ns 23g	eral	5421 85th Ave	12. Was Decedent			20784 Hispanic Origin? (Sp	ecify Yes or No-	U.S.	A ace - Americ	can Indian,
Department of Health and Mental Hygiene Important: If item 27 le marked other than "neturel", or items 23a or 28e-f show say injury or other treumetic event, the Medical Examinar must be notified at ORE.	by	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		ff Yes, specify Cub 1 ☐ Yes 2 ☒ No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	Rican, etc.)	Speci	ack, White, ify: B]	etc. Lack
netur lical	Completed	15. Decedent's (Specify only highest		16a. Deci	edent's Usual Occu	pation during most of worked)	king	16b. Kind of E	Business/In	dustry
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and N le ma eume		19a. Informant's Name/Relationship				t and Number or Rui		•		
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ysician	1	. Decedent's Name (First, Middle,	Last)				2. Date of Dea		3. Time of Death
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miner	4	a. Facility Name (If not institution,	give street and num	ber)	4b. City, Town,	or Location of Death		4c. County of D	
	Į	Prince George's	Hospital,	Center '. Age (In yrs. last bi	cheve	r Ly Winder 24 Hrs.	P Date of Birt	Prince G	
ral tor	3	351-92-3988	1 ∑ M 2□F	26	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day 4-20-	7, Year) 9. 1 78	Birthplace (State or Foreig Country) Nigeria
	-	Isual Residence of Decedent							
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۲	-	19a. Informant's Name/Relationshi			o. Mailing Address (Street				
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-	2	0a. Method of Disposition	. □D	20b. Place o	f Disposition (Name of try, crematory or other pla	ice)	Date	20c. Location - City	or Town, State
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Frances 011er 1512 Joyce TANUARY 16,2005 /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Avundei 9 8. Date of Birth 6/29/1920 Birthplace (State or Foreign Country)
 MT Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F 374-14-5202 84 Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b Counts 28e-f show other traumatic avent, the Medical Examinar must be notified at MD Glen Burnie 1 Yes 2 No Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 21061 USA 384 Fleagle Road Itams 23e Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married ō 1 Yes 2 No Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Menta! Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Secretary Secretarial 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Queenie William Magee 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If itam 27 is any injury or other transonce. Mr. William E. Oller / son 384 Fleagle Road, Glen Burnie, MD 21061 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State 1/17/05 Stevensville, MD Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Funeral Service Lice se M01364 1 Second Ave SW, Glen Burnie MD 21061 23a. Part. Efficient the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FNEUMONIA Enysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) 68760 Physician/Medical as Box (IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. WUnknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: Inpatient 은 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attending 5 Pending investigation 1 Natural after death. 1 🗌 Yes 2 🗌 No 2 Accident 6 Could not be 3 Suicide 28e. Płace of Injury · At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) þ determined 4 Homicide within 24 hours a To the Funerel D 29a. Certifier Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only or(e) and manner stated. tha 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 14,2005 TANUARY DOOTT 973 leassahun M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State
Registrar

HILL WAY

CUTHERLAND

strar's Signature

SILVER SPRING

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44	and the second		State Registrar AMEND TTFM # 1. Decedent's Name (First, Middle, Last)	20b PER FH G	839°F/	ZUTUS SH		2. Date of Deat	th	3. Time of Death
	Physicia	an	Phyllis.	F	arson	5		January	Day Ye	05 520 am
	/Medic Examin	10.00	4a. Fecility Name (If not institution, give stre	eet and number)		4b. City, Town, or I		h	4c. County of [Deeth
e police		- -	Harbor Hospital	Center		Baltin	MOFR.	O Data of Birth		Rights of Contract Services
	Funeral		5. Social Security Number 6. Sex 1 Number 6. Sex	7. Age (In yrs. la	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
	Director	-	Usual Residence of Decedent							
	how		10a. State 10b. County MD Baltimo		Baltiv					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	8a-f s	cto			Dultti			1	l0g. Citizen of Wha	
	3a or 2	Dire	8315 Mindale (ircle #A		10f. Zip Code	21244		•	1.S.A.
9	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland naturent of Heatih and Mental Hygiene. artiment of Heatih and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event. Ite Michigal Examination in the relified at a great property or other traumatic event.	by Funeral Director	1 Never Married 2 Married	Was Decedent Ever in U.S Amed Forces? 1 Yes 2 XNo If Yes, Give		Vas Decedent of His Yes, specify Cubar	spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	Black, \	American Indian, White, etc. BIACK
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Maryland	lbe filed ntal Hygid ad other event, ii	Be	17. Father's Name (First, Middle, Last) POUL K. POUSC	210			01	me (First, Middle, i	^	
2	thould id Mer mark mark	၉	19a. Informant's Name/Relationship (Type	, Print)	19b. Mailir	g Address (Street a				ate, Zip Code)
	nd 2 salth ar allth ar 27 is r trau		Blanche Parson	Mother	8315	Mindal	e Circ	10 #AB	altimor	e, MD 21244
ore,	es 1 a of Hea litem		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Rer	20b. PI	GRIEN	The of ther place	9)		20c. Location - Cit	
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Baltimore,	permit. Page: Department of Important: If i]]	21. Signature of Funeral Service License	1	يُّا	Name and Address Aughra C. C ASP Baltin	s of Facility Treene. Fil note Na	neral se	riico Ce Baltir	11cre ND 21229
↑,			23a. Part 1. Enter the disease, or complications shock, or hear failure. List only one	tions that caused the death cause on each line.	. Do not ent	er the mode of dying	g, such as cardia	c or respiratory arr	rest,	Approximate Interval Between Onset and Death
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Division	Attending ir death. ector: After by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	ome, farm, st			28f. Location (S City or Tow		or Rural Route Number,
Οįς	al or safter	Certi	4 Homicide	building, etc. (Specify	v)			City of You	m, State)	
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	within To the	Re	29b. Signature and title of certifier	/		29c. License	a number		29d. Date signed (Month, Day, Year)
)			KI hit	5 MD		00	OOKE	:5	January	17,2005
	- 1		30. Name and address of person who com Peter Kratz, MD	Sool South	h 23a) (Type, L Hano	Print) ver Stree	+ Balt	imore, N	10 212	27.5
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 2 0 200	pleted cause of death (Item 300 South 32. Jegistrar's Signa	B A	node)				

State Registrar

31. Date filed (Month, Day, Year)

egistrar's Signature

		-	For State Registrar	State of Maryland /	Department of He Certificate of De		ental Hygien Reg. N	71115	01151
	Physici		1. Decedent's Name (First, Middle, Last	F. Pearc	e		2. Date of Death Month	y Year 200	3. Time of Death
	/Medic Examin Funeral		4a. Facility Name In not institution, give North Aru 5. Social Security Number 6. S	e street and number) Ndel Hosp	4b. City, Town, or Lo	ocation of Death Sur f Under 24 Hrs. Hours Min.		9. Birthp	
	Director show	or	Usual Residence of Decedent 10a. State 10b. County	65	wn or Location		2-4-4	MAL	0d. Inside City Limits 1 Tyes 2 No
	death with the Maryland ms 23a or 28a-f show Linual be trofffed at	Funeral Director	10e. Street and Number	RD.	10f. Zip Code	22	10g. (Citizen of What Cour	itry?
0036	hours atter deatl tural', or items 2	by Funera	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No	anic Origin? (Spe Mexican, Puerto I Specify:	ocity Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	an Indian, etc.
)0-c1z1:	within 72 ene. than "nai	Completed	15. Decedent's Et (Specify only highest gra	College (1-4 or 5+)	a. Decedent's Usual Occupation (Give kind of work done durible. DO NOT use retired) MOTOR O	on ring most of working ERATON	ng	Kind of Business/In	dustry
yland z	ld be filed ental Hyg ked othe ic event,	To Be Co	17. Father's Name (First, Middle, Last,	CE	1	MARIE	(First, Middle, Maid	ook_	
re, Mar	1 and 2 Health a em 27 Is ther trait		19a. Informant's Name/Relationship (DAVID PEARCE 20a. Method of Disposition	50N 10 20b. Place	3 Column (Street and of Disposition (Name of tery, crematory or other place)	DAD.	ASADEM	or Town, State, Zip MD - Z 11 Location - City or To	22
saltimore,	permit. Pages Department of I Important: If its any Injury or o		1 Burial 2 Toremation 3 4 Donation 5 Dother (Special 21. Signature of Fune at Service Licer	Removal from State (y)	EW CREMATOR	of Facility	2-05 BX	,	MD.
	Physician		23 Part 1. Enter the disease, or sm shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death. Do one cause on each line.	2601 N	Mountain Road	 Pasadena, MD. 	21122	Approximate Interval Between Onset and Death
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Division of Vital Records,	ıysician: The law re is certificate has bee director, page 2 sho	Completed					24a. Was an autopsy performed 1 ☐ Yes 2 🔼	? death?	opsy findings available ompletion of cause of
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	he Hospit in 24 hours he Funera pletely tille	Medical ((Check only 2 Medical Exa	hysician: To the best of my knowled miner: On the basis of examination and manner stated.	and/or investigation, in my opi	nion, death occurr	red at the time, date a	and place, and due t	o the cause(s)
	Tot Within	M	29b. Signature and title of certifier	Pas, mi		number		Date signed (Month,	Day, Year)
1		nte	30. Name and address of person who are also are also and address of person who are also	32. Registres Signature	D 695	Ame	evicA	210	35
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		1 - For State Registrar	State of Marylar		artment of rtificate o			giene Reg. No. 200	5 01152
/Me	sician edical miner	Decedent's Name (First, Middle, Last Sarah Louise 4a. Facility Name (If not institution, give	Pugh street and number)			, or Location of Dea	January	Day Yea y 17, 2005 4c. County of De	7:30 P M
Funei Direct		1122 B Spalding D 5. Social Security Number 6. Se 219-14-0161 10 Usual Residence of Decedent	7. Age (In yrs.	last birthday)	Bel If Under 1 Yea Months Day			Harfo th Year) 8, 1914 Ma	irthplace (State or Foreign
rith the Marylan or 28a-f show	Director	Maryland Harford 10e. Street and Number		Bel	Air 10f. Zip Code			10g. Citizen of What (10d. Inside City Limits 1 ☐ Yes 2 ☑ No Country?
and 21215-0036 De filed within 72 hours after death with the Maryland ntal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Madical Examinar hourst be notified at	by Funeral	1122 B Spalding 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Drive 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			1014 If Hispanic Origin? (uban, Mexican, Pue Io Specity:	Specify Yes or No- rto Rican, etc.)		
nd 21215-00 e filed within 72 hou il Hygiene. other then "neture	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	ucation	(Give life.	dent's Usual Occ kind of work dor DO NOT use reti maker	ne during most of w	orking	16b. Kind of Busines Own Home	
Maryland 21215-0036 nd 2 should be filed within 72 hours alt lith and Mental Hygiene. 27 is marked other than "natural", or r traumatic event, the Medical Expand	To Be (17. Father's Name (First, Middle, Last) John Edwin Joyner 19a. Informant's Name/Relationship (T)	ype, Print)			Harri	et Stewai Rural Route Numbe	or, City or Town, State,	
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke eny injury or other traumatic.		Paul M. Pugh/Husba 20a. Method of Disposition 1 Subgrigal 2 Cremation 3 F 4 Depration 5 Other (Specify)	20b. F	Place of Dispo cemetery, crer	sition (Name of matory or other p		Date	ir, MD 210. 20c. Location - City of Bel Air,	r Town, State
Balt permit. Depart Import	once.	21. Signatur of Funeral Service Lio as 23a. Partin. Enter the disease, or composition, or heart failure. List only of	15 IN	5	0 W. Bro	dress of Facility Funeral H Dadway St ying, such as cardia	reet. Be	L Air. MD	21014 Approximate Interval Between
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Box 6 sath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 25 No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of di 9 ☐ Unknown	Ideath 3 ☐	Ectopic pregnar Other (specify)			23d. Date of di Month	alivery Day Year
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	e Completed	25. Was case referred to medical				26. Place of De	24a. Was a autop perfor 1 Yes	sy prior to med? death? 220No 1 ☐ Ye	
Afte fune	ation; To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 Inpatient 2 Inpatient 2 Input 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inj W	ther: 4 Nursing	Home 5 Resid	ence 6 Other (Sp ow injury occurred	ecify)
= 2 # c	al Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify sician: To the best of my kno	v) wledge, death	occurred at the	time, date and place	e, and due to the c	ause(s) and manner a	s stated
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Exami	ompleted cause of death (Item	tion and/or in	actionation in mi	aninian daath aan	currend at the time		- 4- 4b 2-3
8		30. Name and address of person who co	ompleted cause of death (Item	23a) (Type,	Print) PLPHAI	Bel.	oin mo	21011	1
	State strar	31. Date filed (Month Day, Year)	32. Room r's Signa	ture	C-10-				

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			For	State of Mar	yland / l				iental Hyg	iene	200	E 0	1 1 5-
		ľ	1 - State Registrar			Certifica	ite of Dea	eth	Re	g. No.	400	0 0	15.
			1. Decedent's Name (First, Middle, Las	st)					2. Date of Deat	h Day	Voss	3. Time of	Death
	Physicia		CAROL	N.		POE	ELL		JANUARY	16.	2005	8:30	Ам
	/Medic		4e. Fecility Name (If not institution, give				y, Town, or Locat	tion of Death			ounty of Death		
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	Funeral Director			□M 2QF	-	Yrs. Month	s Days Hou	urs Min.	8. Date of Birth (Month, Day, APR.13,	1939	Cou	untry) N	ΙΥ
			Usuel Residence of Decedent		- 00				711111209	1303			
pue	š ==		10a. State 10b. County	1	10c. City, Tow	n or Location						10d. Inside Cit	y Limits
Z	- 2	ŏ	MD BALT	IMORE		PIKESVI	LLE					1 🗌 Yes	2 🕅 No
the	28a	ec	10e. Street and Number			10f. 2	Zip Code		1	0g. Citize	n of What Cou	untry?	-
G C I C I 3-0000 filed within 72 hours after death with the Maryland	"natural", or Iteme 23a or 28a-f show	Funeral Director	1 HIGH STEPPER	COUDT #601				21208				USA	
dath	23	era	11. Marital Status		er in U.S.	13 Was Der			ectly Yes or No-	14	. Race - Amer		
p. e.	Ter	5	1 ☐ Never Married 2 💢 Married	12. Was Decedent Ev Armed Forces?	0 0.0.	If Yes, sp	edent of Hispanio ecrly Cuban, Me	xican, Puerto	Rican, etc.)		Black, White		
o de si	, o	by	3 Widowed 4 Divorced	1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		1 🗆 Yes	2 No Spe	ecity:		Sp	pecify:	WHIT	Έ
3 2	tura	pa	15. Decedent's Ed		16a	Decedent's Us	sual Occupation			16b. Kind	of Business/I	ndustry	
2 2	a Sign	jet	(Specify only highest gra	de completed)		(Give kind of v	vork done during use retired)	most of work	ing				
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should	nd Menta marked matic ev	2		Torre Deleth	101				- I Davida Muse has	Churt			
- 0	ie m		19a. Informant's Name/Relationship (190		•		al Route Number #601 -				200
2 2	Health and Mental Hyglene. Item 27 is marked other than "natural", or Iteme 23a or 28a-f shov other treumatic event, the Medical Examiner must be notified at		LEONARD PODELL	/ NOSDAND	20h Blace o	f Disposition (A		_				·	200
5 9	of H		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	cemete	ry, crematory o	r other place)	1	Dere	20c. Loca	tion - City or 1	Iown, State	
Dallillor			' 4 □ Depation 5 □ Other (Specifi	v) /	MI KRO	KODESH	BETH IS	RAEL 1	/17/05	B	ALTIMO	RE, MD	
	Depart Import eny inj once.		21. Signature of Funeral Service Licen	ISOO		22. Name	and Address of F	Facility S	OL LEVIN	SON 8	& BROS	INC.	
n 8	89 5 9		MIMMANY	Tullar	1	8900	REISTE	RSTOWN	ROAD -	PIKE:			
			23a. Pert1. Enter the disease, or com shock, or heart failure. List only	plications that saused the	ne death. Do	not enter the m	ode of dying, suc	h as cardiac	or respiratory arri	est,		Approximate Interval Bety	ween
P	hysician		Immediate Cause (Final	11-0	11	0000	Λ					Onset and [)eath
	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence	of):	lung	\ Com		-			
₽	xaminer			(\)					
4	1258	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Due to (or as a	consequence	of):							
Det	nsit	ri Li	cause. Enter Underlying Cause (Disease or injury										
9 XAC	al-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	consequence	of):							
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X S	ding	/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy					23/	d. Date of deli	Ver.	
ם ל	atter for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 4 ☐ Pregnant at tir	Fetal death	3 □Ectopic 5 □ Other				200	Month	,	/ear
; è	the	Physician/Med	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9□ Unknown	ino or doutin	3 🗆 011107	ароспу/						
F 2	ed by detac		Part II. Other significent conditions of	contributing to death but	not resulting	n the underlying	cause given in F	Part I.	23e. Did tol	acco use	contribute to	the cause of d	eath?
ecords,	sign a be	by							100/1	s 2 🗆 1	No 3∏Pro	obably 4 🗍	Jnknown
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VICE	stiffic stor,	Be (25. Was case referred to medical examiner?				26. 1	Place of Deat	h (Check only on	е)			
>	dire	2	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/O	utpatient 3	DOA Other: 4[Nursing Ho	me 5 Reside	nce 6]Other (Spec	cify)	
2 2	er th		27. Manner of Death	28a. Date of Injury (Month, Day)		Time of Injury	28c. Injury at Work?		28d. Describe ho	w injury o	ccurred		
DIVISION	e fut	atio	1 Natural 5 Pending 2 Accident investigation		, 52,	М	1 Tes	2 🗆 No					
N S	r de octo	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		y - At home, fa	arm, street, fact	ory, office		28f. Location (St City or Town		vumber or Ru	ral Route Num	ber,
בֿ בֿ	Dir	ert	4 _ nonneide	building, etc.	(Specify)				Only of Town	i, Siale)			
a di ca	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Ph	nysician: To the best of	my knowledg	e, death occurr	ed at the time, da	ite and place,	and due to the ca	ause(s) ar	nd manner as	stated.	
I G	Fu Fu letel)	Medical	(Check only 2 Medicel Exar	miner: On the basis of e and manner state	examination ar ed.	nd/or investigati	on, in my opinion	, death occur	red at the time, d	ate and pl	ace, and due	to the cause(s)
5	withir To th comp	Me	29b. Signature and title of certifier	34 /		1	29c. License num	ber	2	9d. Date s	signed (Month	n, Day, Year)	
	> - 0		Dand S	Att	ma out	trad	0172	07		0	1/17/	55	
	1	7	30. Name and address of person who	completed cause of deal	ath (Item 23a)	(Type Print)							
			DAULO ETTINA	er MD	Johns	Hope	us Hos	plal	Relt	inor	e M	a	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	- IOPA	M2 1207	Aile) 5-11	11701)		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 15, 2005 Physician Рм PINSON 6:09 LOUIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 4730 ATRIUM COURT #511 OWINGS MILLS If Under 24 Hrs. 8. Date of Birth MAY 17, 1923 If Under 1 Year 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 2□ F Months Days 214-12-9820 81 Yrs. MD Director Usual Residence of Decedent with the Maryland 10c City Town or Location 10d. Inside City Limits 10h County 10a State ehow tams 23e or 28a-f ehov 1 ☐ Yes 2 ☑ No Director BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Cîtîzen of What Country? 21117 USA 4730 ATRIUM COURT #511 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 ie marked othar then "naturel", or Itar 1 Never Married 2 Married the Mudical Exami Baltimore. Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: WHITE Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) PRINTER PRINTING traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be **TAYLOR** PINSON PHILIP SARAH ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zîp Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i 3826 PAUL MILL ROAD - ELLICOTT CITY, MD 21042 MARLA MONTEMARANO / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) MOSES MONTEFIORE CEM 01/17/2005 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Juneral Serv 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARDIORESTIRATORY disease or condition resulting in death) /Medical **Examiner** ROSCLEROTI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) P.0. the 9□ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ TENSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed 2 No 1 ☐ Yes Division of Vital Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 1 ☐ Yes 2 ☑ No 4 Nursing Home 5 Mesidence 6 □Other (Specify) 2 ER/Outpatient 3F DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. 28d. Describe how injury occurred Certification: After t 5 Pending investigation 1 Natural 1 🗌 Yes death. 2 🗆 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To tha Funeral C 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medicai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ce 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLANDALLE OWN. MAD 2/132 LIBERTY ROAD 8600 M.D.

DHMH 17 Rev 1/200

State Registrar

31. Date filed (Month, Day, Year)

32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 1:55 P hour 18 2005 MYRTLE I. QUINN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death Examiner Arunde Glen Burnie
If Under 1 Year If Under 24 Hrs.
Hours Min. Hrunde 1939 407 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Days Hours Yrs. MD Director 87 MAY 23. <u> 216.12.1581</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ?7 is marked othar than "natural", or Itams 23a or 28a-f show traumatic avent, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Director ANNE ARUNDEL GLEN BURNIE MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 411 PINE TERRACE 21061 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2200 lo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 2 No **XX** Baltimore, Maryland 21215-0036 1 Tes Specify: 3₩Vidowed 4 □ Divorced Specify: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked othar than "r Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER OWN HOME 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HELEN SEYMOUR ARTHUR NASH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an itam 27 is r RAYMOND B. QUINN, JR SON 277 RIVERDALE RD. SEVERNA PARK, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit Pages 1
Department of H
Important: if ita
any in ury or ott Burial 2 Cremation 3 Removal from State VET CEM CROWNSVILLE 1.24.05 MD CROWNSVILLE, MD of Funeral Service Lice complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arraet only one cause on each line. FINK FUNERAL HOME, P.A. Approximate Interval Between Onset and Death 23a. Parl 1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final Myocardia Physician BURG disease or condition resulting in death) /Medical Due to (or as a con-equince of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (pras a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) P.O. I 9 Unknow ate has been signed by a page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 3 Probably 1 ☐ Yes 2 ☐ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy performed? yes 25 No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? ate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending To the Hospital or Attandi within 24 hours after death, To the Funaral Diractor: A death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide i 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Invary 18 2005 DOO 32744 30. Name and address of Arson who completed cause of death (Item 23a) (Type, Print) HOSPITAL

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

301

32. Angistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend items Lba b 20b per fft 9839 1-26-05 vt
State of Maryland / Department of Health and Mental Hygiene Reg. No. 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year REED **Physician** DANVARY E SS1 E 2005 16 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE CENTER PANDALLSTOWN HOSPITAL NORTHWEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 💢 F 217-20-5120 NORTH CAROLINA Director 89 11/23/1915 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County iteme 23a or 28e-f ehow 1 ☐ Yes ACKNO MD BALTIMORE GYWNN OAK Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7311 CASTLEMOOR ROAD 21244 USA 14. Race - American Indian, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married or l Specify: BLACK Baltimore, Maryland 21215-0036 1□ Yes 2☐ No Specify: by ¥¥Vidowed 4 ☐ Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired Cosmetologist Beauty Culture Elementary/Secondary (0-12) College (1-4or 5+) PARK SCHOOL CLEANING SERVICE

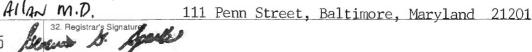
18. Mother's Name (First, Middle, Maiden Surname) 12TH of Health and Mental Hygic Itam 27 is marked other 17. Father's Name (First, Middle, Last) Be DAVID CREWS ETHEL CREWS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY MILLER / GODDAUGHTER CASTLEMOOR RD, 7311 BALTIMORE, MD 21
20c. Location - City or Town, Stete MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 28te permit. Pages 1
Department of HImportent: If Ital
eny injury or ott 1 Burial 2 □Cremation 3 □Removal from State BALTÍMORE NATL CEM 1/24/05 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licensee 23a. And Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. 4600 LIBERTY HGHTS AV, BALTIMORE, MD Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events ding physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ULCERS DECUBITUS 1 Yes 2 No 3 Probably 4 Unknown CEREBROVASCULAR 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate 1 Yes 2 No after death.

Director: After this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Thomicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HANVARY D42723 2005 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH WEST HOSP ITAL C5775R HARISH VERA HALLI 5401 OLD COURT ROAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 2 0

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 0 2005



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O.C.M.E.

January 17, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registra Certificate of Death Reg. No. ** 2. Date of Death Month **Physician** Year 12:03 PM January 4 10 2005 /Medical 4c. County of Death Town, or Location of Death Examiner (In vrs. last birthday, **Funeral** Days 1□M 200F Yrs. Director 10d. Inside City Limits other traumetic event, the Medical Examinar must be notified at 1 Yes 2 No Director 10g. Citizen of What Cour "naturel", or Items 23e Completed by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes 25 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation and Mental Hygiene. (Secondary (0-12) lega (1-4or 5+) Be 2 should be f and Mental I Department of Health and Importent: If Item 27 is ma any injury or other trees. 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine use as the buriat-transit The taw requires that the death certificate be executed @3 the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 X Yes 1 Yes 2 No To the Hospitel or Attending Physiclen: within 24 hours after death.

To the Funerel Director: After this certifics 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 🗌 Yes 2X No 1 Inpatient 2 ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3X DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural Injury 5 Pending 1 🗆 Yes 2 🗌 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Death of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo 21215

DHMH 17 Rev 1/2001

State

Registrar

Ghio Ripehai

JAN 2 0 2005

31. Date filed (Month, Day, Year)

mo

32 Registrar's Signature

evenson

HELTS

est

JOHNNIE SMITH 05-00290 DAP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

023			1 - For State Registrar		artment of Health and N rtificate of Death	Mental Hygier	2005 01150
	Physic /Medi		1. Decedent's Name (First, Middle, Last)	Sm. th		2. Date of Death	3. Time of Death 1, 2005 9:34p M
7	Examir	er	4a. Facility Name (If not institution, give stre 2573 WEST BALTIMORE		4b. City, Town, or Location of Death BALTIMORE CITY		4c. County of Death
	Funeral Director		5. Social Security Number 212-58-34/6 Usual Residence of Decedent	7. Age (In yrs. last birthday) 2□ F	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Murch 27, 19	9. Birthplace (State or Foreign Country) 15 Z 9. Birthplace (State or Foreign Country)
	h the Maryland r 28a-f show notified at	tor	10a. State 10b. County MD W/A	10c. City, Town or Lo	ocation Homore		10d. Inside City Limits 1
	death with the Maryland ms 23a or 28a-f show f must be notified at	Funeral Director	10e. Street and Number 2573 W. B.	Homone St	10f. Zip Code 2/723	10g. (Citizen of What Country?
920	hours after deat turaf, or Items 2 al Examiner mu	by	11. Marital Status 12. 1 □ Neyer Married 2 □ Married	Was Decedent Ever in U.S. 13. Armed Forces? 1 ☐ Yes 2 No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	filed within 72 hours Hygiene. tther than "naturaf", ont, I'le Mydical Exa	Completed	15. Decedent's Educati (Specify only highest grade co	mpleted) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b.	Kind of Business/Industry Con stanction
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Tie M	To Be C	17. Father's Name (First, Middle, Last) Johnny L. S.	.Th. Sr	18. Mother's Nam	e (First, Middle, Maide Hhe S	en Sumame)
	is 1 and of Health item 27 other tr		19a. Informant's Name/Telationship (Type, Precious Sw/H / S 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rem.	20b. Place of Dispo	natory or other place)	Averue Date 20c.	y or Town, State, Zip Code) Bathhorne Man Zizze Location - City or Town, State
Baltimore,	permit, Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Furtheral Service Liensee	NA-518	2. Name and Address of Facility 5126 Below	Funeral A	Senice, P. R. alt. no 21206 5102
	Pnysician /Medical	E 10	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complement of the complement of th	ons that caused the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
30,	cate be executed physician and the burial-transit	I Examiner	Sequentially list conditions, if any, Leading to immuniate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Du to (or as a consequence of):			
. Box 68760,	phy:	Physician/Medical	in the past 12 months?		Ectopic pregnancy J Other (specify)		23d. Date of delivery Month Day Year
rds, P.O.	es De De	by	9 Unknown Part II. Other significant conditions contrib CIVVLOSIS OF LIV	9□ Unknown uting to death but not resulting in the w	nderlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
al Records,	ician: The law requir certificate has been s rector, page 2 should	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 12 Yes 2 No
ion of Vital	ding Phys n. After this funeral di	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ital: 1 Inpatient 2 ER/Outpatien 8a. Date of Injury (Month, Day Year) 2Bb. Time of Injury	t 3 DOA Other: 4 Nursing Ho	n (Check only one) me 5 ☐ Residence 28d. Describe how inj	wy occurred
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 □ Suiside 6 □ Could not be -	8e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
	ne Hospita n 24 hours ne Funeral	edical ((Check only 2/2) Medical Examiner:	n: To the best of my knowledge, death On the basis of examination and/or in and manner stated.	occurred at the time, date and place, a vestigation, in my opinion, death occurr	and due to the cause(ed at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
)	within y To the To the Comple	×	29b. Signature and title of certifier UCOLHAU	laund	29c. Licensa number OCME		ate signed (Month, Day, Year) UARY 12, 2005
	2		CAROLHAI	COLIO VVCEI	Print) PENN STREET, BALTI	MORE, MARYL	AND 21201
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	new live		

			1- State of Maryland / Dep Registrar Ce	artment of Health and Mertificate of Death		iene _{eg. No.} 2005	01160
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Kathleen Stephanie Slone		2. Date of Death Month	- 0	3. Time of Death
	Examir		4a. Facility Name (If not institution, give street and number) Howard County General	4b. City, Town, or Location of Death Columbia		4c. County of Death Howard	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 K 61 Yrs. Vasat birthday, 0 H 1 M 2 K 61 Usual Residence of Decedent	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day Feb. 10		place (State or Foreign htry) Yland
	the Maryland 28a-f show notified at	tor	10a. State10b. County10c. City, Town or LMarylandAnne ArundelSevern	ocation		1	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	3a or 28	Il Director	10e. Street and Number 8049 Fair Breeze Drive	10f. Zip Code 21144	10	Og. Citizen of What Cour	itry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show appriatury or other traumatic avant, the Medical Examination in the rectified at ADRG.	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ▼ Married 1 □ Yes 2 ▼ No	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	within 72 ho ene. than "natur re Medical I	Completed	(Specify only highest grade completed) (Give	ident's Usual Occupation kind of work done during most of worki DO NOT use retired) Honemaker	ing	16b. Kind of Business/Ind	dustry
land 2	uld be filed Mental Hygid Irked othar Itic avant, II	To Be Co	17. Father's Name (First, Middle, Last) Milton Brown	18. Mother's Name Irene Kan			
, Man	and 2 sho Balth and I n 27 is me		Emmett W. Slone / Husband 8049	ng Address (Street and Number or Rura Fair Breeze Drive,			
Baltimore, Maryland	. Pages 1 tment of Hi tant: If iten jury or oth		'4 Donation 5 Other (Specify) Oak Lawn	matory or other place) Cemetery 1/19		Baltimore,	
Ba	permit Depar Impor any in		Achael Conder 4	107 Wilkens Avenue	, Baltim		
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	00 /	or respiratory arres	J 1.	Approximate Interval Between Poset and Death
8760, -	Examiner bhysician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate sause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): C. Due to (or as a consequence of):	0			
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transif	Physician/Medic		⊒Ectopic pregnancy]Other (specify)		23d. Date of deliver	ry Day Year
rds, P	w requires that been signed I should be det	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to the	e cause of death?
al Records,		Completed			24a. Was an autopsy performe	prior to corr ed? death?	osy findings available inpletion of cause of
Division of Vital	Attending Physician: Thr death. ector: After this certificate by the funeral director, pag	atlon; To Be	25. Was case referred to medical examiner? 1			ice 6 ☐Other (Specify,)
Divis	pital or Attenurs after deatl	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury At home, farm, str building, etc. (Specify)		City or Town,		
	To the Hospital or A within 24 hours after To the Funeral Direction completely filled in by	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death and manner stated. Certifying Physician: To the best of my knowledge, death and manner stated.	vestigation, in my opinion, death occurre	ed at the time, date	use(s) and manner as state and place, and due to du	the cause(s)
1	⊢ ≱ ⊢ ŏ		3) Name and a set of person who completed cause of death (Item 23a) (Type,	D 41139	Ju	2n 18th.	2005
	// Sta	te	31. Date filed (Month, Day, Year) 2005 32. Redistrar's Signature	29c. License number D 4-113 9 Print) Utile Patwoent Pa	vency_	Columbia	MD 21044
	Registr		JAN 2 0 2805 Jane 15 /	gods)			

Physician /Medical **Examiner** 10a. State

attending physician and tor use as the burial-transit requires that the death certificate be executed use as the been signed by the should be detached page 2 s this certificate

2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 6:11P M JANVAR Marilyn ٧. Simms 18 2001 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) 7. Age (In yrs. last birthday) GOOD SAMARITAN BALTIMORS | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 16, 1938 5. Social Security Number Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 ☐X 66 Marýland **Director** 214-34-2673 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 and 2 should be filed within 72 hours atter death with the Marylan Heatth and Mental Hygiene.
Itam 27 is marked other than "natural," or Items 23a or 28a-1 show other traumatic event, the Wallcal Endra attentials to publified at 1 Yes 2 □ No Director Baltimore Maryland N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21239 6004 Hillen Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: δ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Thomas Α. Pickett Margaret <u>Hammond</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a 6004 Hillen Road Baltimore, Maryland <u>William R. Simms</u> Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Moreland Memorial Park 1-21-2005 Parkville, Maryland 21. Signature of Foneral Survice Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG **Physician** CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ⚠ No rmeg? 2.X.No 1 ☐ Yes I of the mostrus.

within 24 hours after death.

To the Funerel Director: After this certific. Hospitel or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Res 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 BluD BALLIHORS, MD 212 RAVEN 22 5601 LOCK 31. Date filed (Month, Day, Year) State Registrar JAN 2 0 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 2005 VESNA JANURRY 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) RANDALLSTOWN HOSPITAL NORTH WEST BALTTMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days 1 ☐ M 2 🔀 F 92 Yrs. 348-42-2026 10-5-1912 YUGOSLAVIJA Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 Yes 2 No BALTIMORE REISTERSTOWN MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 32 BROOKEBURY DRIVE APT. 1D 21136 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes ŽQNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify WHITE 3€Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) **JOSEPH** POLASEK ZORA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTIONETTE SKYE/DAUGHTER P.O. BOX 1078 EMMITTSBURG, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State SACRED HEART OF JESUS! 1-21-2005 BALTIMORE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between

Physician /Medical

permit. Page Department of Important: If any Injury or once.

Physician

/Medical

Examiner

10a. State

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at

or other traumatic event,

Pages 1 and 2 should be fil ment of Health and Mental H :ant: If item 27 Is marked otl

Director

Be Completed by Funeral

2

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examiner

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signed by the atte

The law requires that the death certificate be executed

To the Hospital or Attending Physician: after death Director: the filled in by

Division of Vital Records, P.O. Box 68760,

	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	long D	SEASE	atn
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequence of):			
icai Exam	Cause (Disease of Injury that initiated events resulting in death) Last	Due to (or as a consequence of):			
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 250 No 9 ☐ Unknown	13c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of delivery Month Day Yea	ar
ted by Ph	Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of dea	
Complet			24a. Was an autopsy performed?	24b. Were autopsy findings averaged prior to completion of cause death? 1 Yes 2 No	aila se
Be (25. Was case referred to medical examiner?	26. Place of Death	(Check only one)		
To	1 Yes 2 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hom	e 5 Residence	6 ☐ Other (Specify)	
	27. Manner of Death 1 To Natural 5 Pending 2 Accident investigation		Bd. Describe how inju	ury occurred	
dical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	8f. Location (Street a City or Town, Stat	nd Number or Rural Route Numbe te)	Γ,
dical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my knowledge, death occurred at the time, date and place, ar ner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	nd due to the cause(s d at the time, date an	s) and manner as stated. nd place, and due to the cause(s)	

29c. License number

D41410

JOGINDER

RANDAUS TINN MO

29d. Date signed (Month, Day, Year)

January 18th

MEHTA

DHMH 17 Rev 1/2001

10

Registrar

State

within 24 hours a

To the Funeral C

completely filled

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HISPITAL

JAN 2 0 2005

CENTER

			For State Registrar	State of Marylar	nd / Depa		of H	eaith and M		jiene	005	0116	l.
			1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea Month	th Day	Year	3. Time of Death	
	Physici /Medio			John James	Skowro	nski			Januar			2:15 A	М
	Examir		4a. Facility Name (If not institution, give	e street and number)		4b. City, T	own, or	Location of Death		4c. C	ounty of Deat	h	
			Laurel Regional B	Hospital		Laur					ince Ge	eorge	
	Funeral		Social Security Number 6. S	177 M O T F	last birthday)	If Under 1 Months	Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey Dec 5,	Yeer)	9. Birti Co	hplece (State or Forei untry)	gn
	Director		0//-16-8/08	81 81	Yrs.				Dec 5,	1923	New	York	
	and *	}	Usual Residence of Decedent 10a. State 10b. County	10c, C	ity, Town or Lo	ocation						10d. Inside City Limit	ts
	sho sho	ō	MAN TO THE PROPERTY OF THE PRO									1 ☐ Yes 2 ∏ N	10
	28a-1	ect	MD Prince (seorge La	urel	10f. Zip (Code			On Citize	en of What Co	untry?	
	with a or	Funeral Director	6301 Forest Mill	Morrago		207				U.S		-	
	heath ms 23	era	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.			spanic Origin? (Sp n, Mexican, Puerto	ecrly Yes or No-		. Race - Ame		_
(0	r Iter	필	1 ☐ Never Married 2 🔯 Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give					Rican, etc.)		Black, White	e, etc.	
3	e surs a	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	Ø No	Specify:		5	ipecify: Wh	ite	
21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual	Occupa done d	ation during most of work)	ing		d of Business/	•	
21	ithin ithin	nplo	Elementary/Secondary (0-12)	College (1-4or 5+)			retired,)			ted Sta		
2	led w lygier her th		47 Fabruary (First Middle Last	4	Anal	yst	1	18. Mother's Name	o (First Middle		ernment	-	
and	be fi	Be	17. Father's Name (First, Middle, Last)								umame)		
3	ould Mer narke	၉	James Skowronski	Time Orint)	10h Maili	n = Addroon	(Street o	Julia Cz and Number or Run			Town State 7	Fin Codel	
Maryland	12 sh h and 7 is n traur		19a. Informant's Name/Relationship (Edith J. Skowrons									Land 20707	
	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show enty injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition	20b.	Place of Dispo	sition (Nam	e of		The second secon		ation - City or		
ğ	nt of nt of t: # It		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, cres	•		1	10 05	~ F ~	M		
Baltimore,	artme artme ortan injury		21. Signature of Funeral Service Licer		2:	2. Name and	Addres	ory Jan is of Facility			ton, M	aryland	
Ba	Depared Important in once.		X 4/4/	1//	D	onalds	on !	Funeral E t Ave. La	lome, P.	Α.	700 5	707 4200	
			23a. Part1. Enter the disease, or com	plications that caused the dea	th. Do not en	ter the mode	of dying	g, such as cardiac	or respiratory arr	est,	and 201	Approximate Interval Between	
	Physician		shock, or heart milere. List only Immediate Cause (Final)		**	m / 1						Onset and Death	
	/Medical		disease or condition resulting in death)	a. Congestive Due to (or as a conse		Failur	e					days	
- 6	Examiner			b. End Stage R	enal D	isease	2					years	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter underward	Due to (or as a conse									
11	nd nd transi	Examiner	cause. Enter uniderlying Cause (Disease or injury that initiated events	c. Hypertensio								years	
0,0	uires that the death certificate be executed signed by the attending physicien and deep detached for use as the buriat-transit	E	resulting in death) Last	Due to (or as a conse	quence of):								
8760	ate b	dicai		d									
x 68	certificat Iding physse as th	/Me	IF FEMALE:	23c. If yes, outcome of pregr	ancy								
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fet	aldeath 3[□Ectopic pre				23	ld. Date of del Month	Day Year	
o.	he de	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	death 5	_ Other (spe	y/			ŀ			
P.0	requires that the death been signed by the atter hould be detached for u	h h	Part II. Other significant conditions of	contributing to death but not re	sulting in the u	inderlying ca	use give	en in Part I.	23e. Did to	bacco us	e contribute to	the cause of death?	
ds	uires sign ld be	d by	Prostate cancer		Colon	cance	r		1 🗆 Y	es 2 🂢	No 3 Pr	obably 4 Unknov	٧n
100	w require been sign	Completed	Atrial fibrillat	-ion	Pneumo	onia			24a. Wasa	ın	24b. Were au	topsy findings availab completion of cause o	ole
Re	The law ite has b	ma	Atherosclerosis		Strok		71		autops	med?	death?	completion of cause o	ł
ta	sician: The law certificate has b irector, page 2 s	0	25. Was case referred to medical		SCION	E (199	7)	26. Place of Deat	1 ☐ Yes		1 1 103	24110	
>	Physician: this certific ral director,	OB	examiner? 1 ☐ Yes 2 🏿 No	Hospital: 1X Inpatient 2] ER/Outpatie	nt 3 🗆 DO	Othe	er: 4 Nursing Ho			□Other (Spec	cify)	
0	g Ph ter th neral	n: T	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day Yeer)	28b. Time o	of 28	c. Injury Work	at	28d. Describe h				
.0	Attending r death.	atlo	2 ☐ Accident investigatio	n	1,	М		Yes 2 □ No					
Division of Vital Records,	r Atterderinecte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, st	reet, factory,	office		28f. Location (S City or Town	treet and n. State)	Number or Ru	iral Route Number,	
Q	itel o	Ce											
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exat	nysician: To the best of my kn miner: On the basis of examin									
	the the the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		290	License	number	2	9d Date	signed (Monti	Dev Year)	
	To To To		255. Organization and time of continuity	8 M		٠			1				
	/ .		30. Name and address of person who	C. F. J. J.	m 22=\ CT =		2542	<i>L L</i>		Janu	ary 17	, 2005	
	15+1		30. Name and address of person who Robert Maggin, M				110	Laurel,	Marylan	3 205	707		
	Str	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign		- II V CII	401	HAULGI,	. ICL y Lain	. 201	37		_
	Regist		- JAN 2 0 2	OOF A	4	last.							

ORIGINAL

			For	State of Maryland				ental Hyg	iene	01165
			State Registrar		Cer	tificate of De			g. No./ UU	U1165
	Physicia	an	Decedent's Name (First, Middle, La	st)				Date of Deat Month	Day Year	3. Time of Death
	/Medic			ouise Simes	3	45 Oh T		January	19, 2005 4c. County of Deat	6:35A M
	Examin	er	4a. Fecility Name (If not institution, giv			4b. City, Town, or Loca				
			Anne Arundel Med: 5. Social Security Number 6. S		last hirthday)	Annapol:		8. Date of Birth	Q Rie	Arundel
	Funeral Director		1	1□M 2\□F 90	Yrs.		ours Min.	Month, Day, Dec. 20		thplace (State or Foreign buntry) SW Jersey
		-	158-38-6165 Usual Residence of Decedent	90				Dec. 20.	1714	ew Jersey
	yland		10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits
	Mar si	ig	Maryland Anne Art	undel	Se	verna Park				1 ☐ Yes 2X☐ No
	11 th	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
	within 72 hours after death with the Maryland liene. Than "natural", or Items 23a or 28a-f show the Madeal Examination at		14 Sunset Drive			21146			United S	
	r dea	Funeral	11. Marital Status	12, Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent of Hispar f Yes, specify Cuban, M	nic Origin? (Spe lexican, Pu <i>e</i> rto F	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
20	within 72 hours after ene. than "natural", or Ite he Medical Examirie	by Fu	1 Never Married 2 Married	1 □Yes 2 XNo		I□Yes 2∏No Sp	oecify:		Specify: 1.11	hito
315-0036	hour tural		3 Widowed 4 ☑ Divorced 15. Decedent's E	Year or Dates:	16a Decer	lent's Usual Occupation			16b. Kind of Business	nite /Industry
<u>.</u>	in 72	ete	(Specify only highest gro	ade completed)	(Give	kind of work done during OO NOT use retired)	g most of workin	ng		,
	with ene. than	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		Homemaker			Own Ho	ome
	Hyg The	0	17. Father's Name (First, Middle, Last)		18.	Mother's Name	(First, Middle, I	Maiden Surname)	36.5
<u>a</u>	lid be lental rked c	To B	Enoch Be	olles			Clara		Kaufman	
a S	nd 2 should be ilth and Mental 27 Is marked or r traumatic ev	Г	19a. Informant's Name/Relationship	Type, Print)	19b. Mailir	ng Address (Street and I	Number or Rura	l Route Number	City or Town, State,	Zip Code)
	and 2 ealth a n 27 l		Patricia S. Oelke			inset Drive			k, Maryland	
Baltimore,	- H = +		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □	20b. P	lace of Dispo emetery, crer	sition (Name of natory or other place)	D	ate	20c. Location - City or	Town, State
Ĕ	permit. Pages Department of I Importent: If its any injury or o		* 4 □Donation 5 □Other (Speci	(y) Wes	st Arui	idel Cremat	ory 1/20	0/2005	Odenton, 1	Maryland
ă	sparti sport sport		21. Signa up of Funeral Service Lice	n/e	Da	Name and Address of naidson Fu	neral Ho	ome & Cr	rematory,	P.A.
n	20529		Quanita &	Thomas MOC	0957 14	11 Annapol	is Road	Odento	on, Maryla	
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	plicetions that caused the death one cause on each line.	h. Do not <i>e</i> nt	er the mode of dying, su	uch as cardiac o	r respiratory arr	est,	Approximate Interval Between Onset and Death
14	Pnysician ·	8 7	Immediate Cause (Final disease or condition	a. Kespina	tory	faile	ul			
	/Medical Examiner		resulting in death)	Due to (or sa consequence	uence	1718				
	LAdiiiiici	L	Sequentially list conditions,	b. Due to (or as a conseq.	conve					
1	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	203 10 (01 03 0 0011100)	asino siyi					
	xecul and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):					
8760	death certificate be executed e attending physician and ad for use as the burial-transit	dlcal E		d						
89	ificate g phy as the	edic		U						
Rox	leath certific attending pl I for use as t	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1□Live birth 2□Feta		Ectopic pregnancy			23d. Date of de	
ň	death e atte	icla	in the past 12 months? 1 \(\subseteq Yes \) 2 \(\subseteq No \)	4☐Pregnant at time of d		Other (specify)			Month	Day Y <i>e</i> ar
J.	res that the de igned by the a be detached f	Physiclan/Me	9 Unknowň	•			-			
_	requires that the been signed by th hould be detache	by	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause given in	1	1000	bacco use contribute to	
Vital Records,	w require been sig should t	Completed by	aprille sisi	maxion n	770010	y la venous	con resp	90 0 1□Y	es 2 □ No 3 ₽₽	robabły 4 ∏Unknown
မင် မင်	¥ 11 0	ble	Chronie 055+	untive per	mon	ay disa	nse	24a. Was a autops	y prior to	utopsy findings available completion of cause of
<u> </u>	T age	DO.						perform 1 Yes		2 □ No
ıta	Physician: The la r this certificate haveral director, page 2	Be (25. Was case referred to medical examiner?	Managaria to			. Place of Death	(Check only on	ne)	
5	hysi this c	၉	1 Yes 2 40		ER/Outpatier				ence 6 Other (Specow injury occurred	ecify)
Ĕ	ling F	ion	27. Manner of Death N☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Work?	2 🗆 No	EDG. DOSCIDO IN	ow injury occurred	
<u>s</u>	uttendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not	be 390 Place of Injury - At he	ome, farm, sti			28f. Location (S	treet and Number or R	ural Route Number,
Division of	after Direction by	Certification:	4 ☐ Homicide determined	building, etc. (Specif	(y)	oot, tastery, other		City or Town	n, State)	
	spital		29a. Certifier 1 Certifying P	hysician: To the best of my kno	wiedge, deat	h occurred at the time, d	date and place, a	and due to the c	ause(s) and manner a	s stated.
	e Ho	Medical	(Check only 2 Medical Exe	eminer: On the basis of examina and manner stated.	ition and/or in	vestigation, in my opinio	on, death occurre	ed at the time, d	ate and place, and du	e to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely illied in by the funeral director.	Me	29b. Signature and title of certifier			29c. License nu	mber	2	9d. Date signed (Moni	th, Day, Year)
)	_		Fridak	Josa Hers	ets	D 4	337	/	1/19/0	18
	m		30. Name and address of person why	completed cause of death (Iten	n 234) (Type,	Print)				
	"		Jetry W	JUSEVY -A	ERBE	ant with 1	PHES		<u></u>	
	Sta		.31. Date filed (Month, Day, Year)	2. Registrar's Signa	ature	20				
	Regist	ar	JAN 2 0 200	3 Marie S						

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2005 7:45a. January 11 C. Sterrett Jr /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5705 Fieldview Ct. Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12 18 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours 1 □ M 2 □ F MD 219-12-8969 81 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Exacting Figurit be rictified at once. 10a. State 10b. County 1 Yes 2 □ No MD NA Baltimore Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A.

14. Race - American Indian,
Black, White, etc. 5705 Fieldview Ct. 21207 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No If Yes, Give 11. Marital Status 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2/CMNo Specify: Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) McCormick Company 10th grade Supervisor 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Sumame) Be Carrie Sterrett Thomas C. Sterrett Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cametery, cramatory or other place)

5705 Fieldview Ct., Baltimore, Md. 212

20c. Location - City or Town, Stete 21207 Bernice Sterrett-Wife 20a. Method of Disposition ty Neurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 1/20/05 Owings Mill, Md Garrison Forest 22. Name and Address of Facility
March F/H West 21. Signatur of Funeral Service Licensee CRome Shimpour 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) MAC **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) Records, P.O. Box 68760, been signed by the attending physicien should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 Z No certificate 1 ☐ Yes 2√2 No Division of Vital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b Time of 28c. Injury at Work? After t Injury 1 Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🔲 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours a To the Funerel [1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

CPM 05-00328 Bobby Ray Stout

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien [] [] 5 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Bobby Ray Stout, Sr. 13, January 2005 17:44 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Laurel Regional Hospital Laurel 8. Date of Birth (Month, Day, Year) Mar 13, 19 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 1 ★ M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 219-84-8594 40 Yrs. Director ΜD Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits or items 23a or 28a-f show 1 ☐ Yes 2 No Directo Calvert Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 1855 Kingswood Drive 20678 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. the Medical Examiners within 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: 3 Widowed 4 Divorced White "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If item 27 is marked other then any injury or other treumatic event Elementary/Secondary (0-12) College (1-4or 5+) 12 Driver Delivery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Stout Stella Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1855 Kingswood Drive, Sheila Stout / wife Prince Frederick, MD 20678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Jan 18, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 2005 Stevensville, Maryland 21. Signature of Funeral Şervice Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. 1 Second Ave SW, MO1357 Glen Burnie, MD 21061 and 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATTHEMOS CLEMOTIC CAMIOVAS CHUN DIS OBSE **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, is along to infinite solutions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for as a consequence off: burial-transit Due to (or as a consequence of): Box 68760 the attending physician an/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month \overline{c} 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. detached Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 robably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) XXYes 2 No 2 1 Inpatient 2X ER/Outpatient 3□ DOA this 27. Many or of Death uneral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation death. 1 TYes 2 No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 15, 2005 30-Name and address of person who completed cause of death (Item 23a) (Type, Print) HARYA DU LOREU 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature State Stewn & Special ORIGINAL 2005 Registrar

			1 - For State of Registrar		artment of Health and rtificate of Death		ne.2005 01168	
	Physici		1. Decedent's Name (First, Middle, Last) Stevenson Simms			2. Date of Death January	3. Time of Death 6:30 A M	
	/Medi Examir		4a. Facility Name (If not institution, give street and numb	er)	4b. City, Town, or Location of Dea		4c. County of Death	
			77 College Creek Terrace Annapolis Anne A					
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday) 56 Yrs.	If Under 1 Year If Under 24 Hr Months Days Hours Min		9. Birthplace (State or Foreign Country) 1948 Maryland	
L,	Director		214-46-0709 XXM 2□F Usual Residence of Decedent	OO Yrs.		Apr 12	1948 Maryland	
	yland		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits	
	Ba-f s	ctor	Maryland Anne Arundel	Annar	oolis		1X Yes 2 □ No	
	23e or 24	Funeral Director	10e. Street and Number 77 College Creek Terr	ace	10f. Zip Code 21401	10g.	Citizen of What Country? USA	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. ad other then "natural", or items 23e or 28e-f show event, the Modiral Example I was be rediffed at	by	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Oivorced 12. Was Decede Armed Force 1 7 September 1 7	ont Ever in U.S. 13. es?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2♥ No Specify:	Specify Yes or No- irto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black	
15-0	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	orking 16t	b. Kind of Business/Industry	
212	filed within Hygiene.	omp	Elementary/Secondary (0-12) College (1-4	or 5+)	ary Assistant		ne Arundel Co.	
nd	be filed ital Hygie of other	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Na	ame (First, Middle, Maid	den Sumame)	
yla	2 should be and Mental is marked o	To	Joseph Simms			la Willia		
		1 8	^{19a.} Informant's Name/Relationship <i>(Type, Print)</i> Bessie Johnso m (Sister)		ng Address <i>(Street and Number or F</i> Roosevelt St.			
Baltimore,	of of	1 8	20a. Method of Disposition 1	20b. Place of Dispo	sition (Name of matery and name of		. Location - City or Town, State	
ţim	Par Tipe		* 4 ☐ Donation 5 ☐ Other (Specify)	Par			napolis, Md.	
Bal	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee Larry H. Reess Moc	183 E	2. Name and Address of Facility Jm. Reese & Son 321 West St. A	ns Mortua nnapolis,	ry A. P.A.	
П			23a. Part1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do not ent h line.	er the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	as a consequence of):	Concer		Onor and Death	
	Examiner		2	we pri	tactores			
(pe jis	iner	Sequentially list conditions, tary leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of):				
_,	ate be executed hysician and the burial-transit	Examiner	that initiated events	as a consequence of):	anlly			
8760	cate be e ohysiciar the buri		d:					
89	ortifical ing phy	Medi	IF FEMALE:					
.O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physiclan/Medical	23b. Was decedent pregnant in the past 12 months?	2 ☐ Fetal death 3 ☐ t at time of death 5 ☐	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
S, D	ss tha	by P	Part II. Dther significant conditions contributing to deat	n but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?	
ord	w require been się should t	ted				1 🗆 Yes	2 No 3 Probably 4 Unknown	
H	The law ate has b page 2 sl	Completed				24a. Was an autopsy performed 1 Yes 2		
Vita	Physician: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner? Hospital:			eath Check onl one)		
of	l or Attending Phys after death. Director: After this I in by the funeral di	on: To	27. Manny of Death 28a. Date of I	atient 2 ER/Outpatien njury 28b. Time of Day Year) Injury	28c. Injury at Work?	Home 5 Hesidence 28d. Describe how in		
Division	Attending r death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of	Injury - At home, farm, stre	M 1 Tyes 2 No	28f Location (Street	and Number or Rural Route Number,	
Ω	To the Hospital or Attenwithin 24 hours after deat To the Funaral Director: completely filled in by the	Certification:	4 Homicide building,	etc. (Specify)		City or Town, St	rate)	
	To the Hosp within 24 hor To the Fune completely fi	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the besidence of the control of the properties of the control of	of examination and/or inv	occurred at the time, date and plac restigation, in my opinion, death occ	e, and due to the cause urred at the time, date a	v(s) and manner as stated. and place, and due to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier	-	29c. License number	į.	Date signed (Month, Day, Year)	
)	1		Curtis Har	un ml	05330	6	1/14/05	
	り		30. Name and address of person who completed cause of	f death (Item 23a) (Type,	Print) estacto R.O	Stp 211	Annapolis in D	
	Sta	te	31. Date filed (Month, Day, Year) 32. Regi	strar's Signature	3/94/6 100	216 411	in polis mi	
13.	Registr	ar	JAN 2 0 2005	, LI KADANA				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Elizabeth Tennery Ĭ5, January 2005 2:13 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea April 7, 1 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕅 F Director 579-32-1088 Yrs 1926 78 Oklahoma Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Maryland Montgomery Rockville ec 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with ā 9909 Silverbrook Drive 20850 death v United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Exemples. Once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: White 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Partner/ Elementary/Secondary (0-12) College (1-4or 5+) Attorney Law Firm 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Claude Victor Tennery Pearl Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian A. Tennery / Son 17102 Campbell Farm Road, Poolesville, Maryland 20837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State January 18 Montgomery Crematorium, Inc. ⁴ 4 □ Donation 5 □ Other (Specify) 2005 Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Angelette Bays M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Priysician Emphysema disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 XNo Month Day Year 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Pelvic Abscess, Diverticulitis 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an was ... autopsy performed? Ves 22 No 1 ☐ Yes or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 🔀 Inpatient 1 ☐ Yes 2 🔀 No Other: 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 5 Pending investigation 1 Tyes after death. 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D4218 30. Name and address of person while completed cause of death (Item 23a) (Type, Print) Enrique Daza, M.D. 106 Irving St. N.W., 3400N, Washington, D.C. 20010 31. Date filed (Month, Day, Year) State JAN 2 0 2005 Registrar

		1 - For Amend Iter State Registrar 1. Decedent's Name (First, Middle,	. Last)				2. Date of Death Month	Day Year	3. Time of Death
Physicia /Medic		Edward			Thomas	Sr.	ANUARY	6,2005	- 17:02 M
Examin	er	4a. Facility Name (If not institution,	/		4b. City, Town,	or Location of Death	,	4c. County of Dea	th
		5. Social Security Number	ES HEALTH	e (In yrs. last birthday	13HL/	If Under 24 Hrs.	O Data of Pint	1	
Funeral Director		215-24-9057 Usual Residence of Decedent	XIXM 2□F	75 Yrs.	Months Days		8. Date of Birth (Month, Day, Ye. 11 15	29 9. Bir	thplace (State or Foreign ountry) MD
yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
h the Marylan or 28e-f show	ctor	MD NA		Baltin	ore				1X Yes 2 □ No
or 28e-f	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	ountry?
s 23e	eral	4604 Fairview		F 110		21216		U.S.A	
	by Funeral [11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? ed 1 Yes 2 N If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spe pan, Mexican, Puerto I Specity:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	te, etc.
15-0036		15. Decedent's	s Education	16a. Dece	edent's Usual Occu	pation	16b	Kind of Business	Black
- C - C - C - C - C - C - C - C - C - C	Completed	(Specify only highest Elementary/Secondary (0-12)	t grade completed) College (1-4or 5	(Give	a kind of work done DO NOT use retire	during most of workingd)	ng		
Ind 2121; be filed within I tal Hygiene." d other then "	Соп	12th grade	na		ntenanc	e	U.	.S. Pos	tal Servi
be file that the other of other over the other over	Be	17. Father's Name (First, Middle, L	ast)				(First, Middle, Maid	len Sumame)	
arylan should be nd Mental marked o	70	Oliver Thomas	in (Toron Orient)			Mary Mo			
Z 122		19a. Informant's Name/Relationshi				t and Number or Rura			
		Henry Thomas- 20a. Method of Disposition	Son	20b. Place of Disp cemetery, cre	osition (Name of	ort Ave,		Location - City or	
		1 Burial 2 □ Cremation : 4 □ Donation 5 □ Other (Spe				1			Mills, Md
事 교문원공 [21. Signature Funeral Service Li					/13/03 (Jwings	MIIIS, Mu
Bal Permir Depar Import		Nonald	C Jun	Út 1	2. Name and Addre larch F/ 1300 Wah	H West bash Ave,	Baltimo	ore. Md	21215
		28a. Part1. Enter the disease, or o	complications that caused	the death. Do not en	ter the mode of dyi	ing, such as cardiac o	respiratory arrest,		Approximate Interval Between
Priysician		Immediate Cause (Final sease or condition			nfare	hen			Onset and Death
/Medical Examiner		resulting in death)	Due to or as	a consequence of):			,		2 - (0 - (
200	_	Sequentially list conditions,			rardou	escula	discol	C	10 years
led sit	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Ditta to (or as a	a nonsaquence of):					
execu	xar	that initiated events resulting in death) Last	C Due to (or as	a consequence of):					
	cat		d						
ox 68' certificat nding phy									
Box (Bot learlif Bath certif attending for use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Dectopic pregnanc	v		23d. Date of del	•
Bo Bo Beath he atten	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown		Other (specify)	,		Month	Day Year
P.O.	Physician/Med	9 Unknown	2.4				00 50		
Records, P.O. The law requires that the ten been signed by the bage 2 should be detached.	Completed by	Part II. Other significant condition		_				_	the cause of death? obably 4 Dunknown
Cord	etec	Melastate p-	V) FAIRC CON	ice - D	2-1-1-1-	1		2UN0 3UP	
Vital Records siclen: The law requires certificate has been sign irector, page 2 should be	mpl	5Chitopholax					24a. Was an autopsy performed?	prior to d	itopsy findings available completion of cause of
al n: Th		05.31					1 Yes 2		2 🗆 No
Vita siclen: certific irector,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Ott	26. Place of Death			
hy hy la	 	27. Manner of Death	28a. Date of Injur (Month, Day		. 0 20.1	4 - 1101311g 11011	e 5 Residence 8d. Describe how in		cify)
	t o	1 Natural 5 ☐ Pending 2 ☐ Accident investiga		Year) Injury	Wo	rk?]Yes 2□No		,,	
inding F	497	3 ☐ Suicide 6 ☐ Could no	and 286. Place of Inju	ury - At home, farm, st	reet, factory, office	2	8f. Location (Street	and Number or Ru	ıral Route Number,
vision of Vital r death. r death. ector: After this certifica	ifica		building, etc	с. (Эрөспу)			City or Town, Sta	ite)	
Division of Vital set or Attending Physiclen: 1 s after death. e) Director: After this certificat ed in by the funeral director, p	Certifical	4 Homicide				1			
urs urs arel	dical Certification:	29a. Certifier (Check only 2 Medical E:	Physician: To the best of xaminer: On the basis of	examination and/or in	h occurred at the te vestigation, in my o	me, date and place, a opinion, death occurre	nd due to the cause d at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
urs urs arel	Medical Certifical	29a. Certifier (Check only one) 29 Medical E	Physician: To the best of xaminer: On the basis of and manner sta	examination and/or in	vestigation, in my o	opinion, death occurre	d at the time, date a	nd place, and due	to the cause(s)
he Hospite n 24 hours he Funerel pletely filled	edical	29a. Certifier (Check only one) 29b. Signature and title of certifier	and manner sta	examination and/or in	29c. Licens	opinion, death occurre se number	d at the time, date a	nd place, and due ate signed (Mont)	h, Day, Year)
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urs urs arel	edical	29a. Certifier (Check only one) 29 Medical E	and manner sta	examination and/or in ted.	29c. Licens Print)	opinion, death occurre se number	d at the time, date a	nd place, and due ate signed (Mont)	h, Day, Year)

		1 - State of Marylan		artment of H			iene g. No.2005	5 01171	
	-	Decedent's Name (First, Middle, Last)				2. Date of Deat Month		3. Time of Death	
Physic /Med		Isaak Vaynrub				januar			
Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or			4c. County of De		
		Northwest Hospital Center			11stown		Baitin		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I		If Under 1 Year Months Days	Hours Mir		Year) 9. B	irthplace (State or Foreign Country) UKRAINE	
Director		215-33-9241 TX 99				SEPI.I,	1905	UKRAINE	
yland iow			, Town or Lo	ocation				10d. Inside City Limits	
Man,	ţ	MD BALTIMORE	PIKE	SVILLE				1 ☐ Yes 2 📈 No	
th the	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What		
ath wi	rai	4204 OLD MILFORD MILL ROAD			21208			USA	
ar deg	Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (an, Mexican, Pue	Specify Yes or No- into Rican, etc.)	14. Race · An Black, W!	nerican Indian, nite, etc.	
s afte	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give 1 □ Yes 2 ☒ No Specify: Specify:						WHITE	
thon structural	ed	15. Decedent's Education	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busines	s/Industry	
Na nic 7 nic	piet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life.	kind of work done DO NOT use retired	during most of w d)	orking			
d with	Completed	2	B00K	KEEPER			RAILROAD		
Idn yidnitu Z IZ IS-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene a marked other than "natural", or items 23a or 28a-f show sumstic event, the Madical Examinar must be notified at	Be (17. Father's Name (First, Middle, Last)				ame (First, Middle, I	Maiden Sumame)		
should the marked umarked	10	NOAH	VAYN		SURA			SMOLAR	
ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. It of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Maddral Examinar must be notified at		19a. Informant's Name/Relationship (Type, Print)					City or Town, State		
C, 10		YEVGENIYA KUSHNIR / DAUGHTER 20a. Method of Disposition 20b. P	_	MARSUE [OKIVE #1		IMORE, MD 20c. Location - City		
Pages nent of H		1 X Burial 2 □ Cremation 3 □ Removal from State	emetery, crei	matory or other plac					
mit. Pages partment of portant: If it y injury or o		. 4 □ Donation 5 □ Other (Specify) HAR 21. Signatura of Funeral Service, Licensee		CEMETERY Name and Addre		18/2004		MILLS, MD	
parmit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		Day Aling	Q	ann peter	FRSTOWN	DUTU - D	ON & BROS	, MD 21208	
		23a. Parti Enter the disease, or Amplications that caused the death show, or leart failure. Let only one cause on each line.						Approximate	
Physician		Immediate Cause (Final						Interval Between Onset and Death	
/Medical		disease or condition resulting in death) Due to (or as a consequence)		tavt Fai	luve				
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n =	ne	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of the conditions).	uence of):						
acuted nd transi	Examine	Cause (Disease or injury that initiated events c.							
cate be executed physician and the burial-transit	Ë	resulting in death) Last Due to (or as a consequence of the consequenc	to (or as a consequence or).						
cate b	dicai	d						1	
The Colids, T.O. BOX of The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregna	incy				23d. Date of d	elivery	
eath atten	cian	in the past 12 months?	Ideath 3	□Ectopic pregnancy □ Other (specify) _	1		Month	Day Year	
the d	ysi	1 Yes 2 No 9 Unknown 9 Unknown							
that shad be deta	by Pt	Part II. Other significant conditions contributing to death but not res	ulting in the u	inderlying cause giv	en in Part I.	23e. Did tot	acco use contribute	to the cause of death?	
quire;		Acute venal failure				1 □ Y€	es 2□No 3□	Probably 4 Unknown	
law requires law signer as been signer 2 should be	Completed					24a. Was a		autopsy findings available completion of cause of	
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iclan: T	Be	25. Was case referred to medical examiner?			26. Place of D	eath (Check only on			
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ng P	on:	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor		28d. Describe ho	w injury occurred		
SIC tendl leath. tor: A the fu	cati	2 Accident Investigation 3 Suicide 6 Could not be 28e Place of Injury - At h			Yes 2 □ No	206 Location (Co	mat and Number or	Pum I Pouto Number	
lor Attending after death. Director: After in by the fune	ertification:	4 Homicide determined 28e. Place of Injury - At the building, etc. (Specific	y)	reet, factory, office		City or Town		Rural Route Number,	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	O	29a. Certifier Certifying Physician: To the best of my kno	wiedge, deat	h occurred at the tir	ne, date and place	ce, and due to the ca	ause(s) and manner	as stated.	
24 h(3 Fun etely	edical	(Check only one) 2 Medical Examiner: On the basis of examina and manner stated.							
o the	Me	29b. Signature and title of certifier		29c. Licens	e number	2	9d. Date signed (Mo	nth, Day, Year)	
. ,, , ,		Maying MegiaMD		000	000547	-	january	15,2005	
į		30. Name and address of person who completed cause of death (Item	n 23a) (Type,	Print) Man	iov Meii	a	/		
		5401 OH court Road Rav	idallst	DINN, ME	avyland	21133			
	tate	30. Name and address of person who completed cause of death (Item S401 OW COLIV+ 2003 Ray 31. Date filed (Month, Day, Year) 32. Regulars's Signal JAN 2 0 2005	iture //	Soule	(
Regis	trar	JAN 2 0 2000	100						

			1 - For State Registrar	State of Marylan	d / Depa	artment of Hortificate of L	ealth and M	lental Hygie	-	01172	
	Physic /Medi		1. Decedent's Name (First, Middle, Last) JAMES W	Dilson				1 1	Day Year	3. Time of Death	
	Funeral Director	ner	4a. Facility Name (If not institution, give to the control of the	General x 7. Age (In yrs.	last birthday) 72 Yrs.	4b. City, Town, or If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	4c. County of Deat		
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Itams 23a or 28a-f show ont, the Madical Examinat must be motified at	Funeral Director	10a. State 10b. County MD Howard 10e. Street and Number LOTT MeadOWnic	75	10g.	Citizen of What Co	A CONTRACTOR OF THE CONTRACTOR				
9600	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any finjery or other traumatic event, the Madical Examinational by multifulutal any foliage.	þ	11. Marital Status 1 ∰ENever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 2 ⊠No If Yes, Give Year or Dates:		Was Decedent of His f Yes, specify Cuban 1 □ Yes 2 🖾 No	panic Origin? (Spe , Mexican, Puerto Specify:		14. Race - Ame Black, White Specify: 13 L	rican Indian, o, etc. ACK	
nd 21215-0036	filed within 72 h Hygiene. Ither than "natu	Be Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) THI Grade 17. Father's Name (First, Middle, Last)	cation e completed) College (1-4or 5+)	(Give life.	dent's Usual Occupa kind of work done do DO NOT use retired) _a n (SC)	uring most of working	ng 16b	Rind of Business/		
Maryland	2 should be f and Mental I Is markad of aumatic eve	To B	Richard Wilson 19a. Informant's Name/Relationship (Ty)	pe, Print)	19b. Mailir	ng Address (Street ar	nd Number or Ruga		y or Town, State, Z		
	Pages 1 and nent of Health int: If item 27 iry or othar tr		Janus (Johns 20a. Method of Disposition 1 🗷 Burial 2 Cremation 3 🗆 R	20b. Pi	emetery, crer	sition (Name of natory or other place			Location - City or IKridge		
Baltimore,	permit. Pa Departmen Important any injury once.		21. Signature of Furreral Service Licent			Han Commula Name and Address Augus C. C	Hacility 71		Vicio		
	Frysician	3 4	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)								
8760, 二,	Medical Examiner hysician and hybridan and he burial-transit	ical Examiner		Due to (or as a consequence of the consequence of t	uence of):					r	
.O. Box 6	the death certific by the attending p ached for use as i	Physician/Medi	#F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			23d. Date of delin	rery Day Year				
rds, P	w requires that been signed b should be det	b	Part II. Other significant conditions con	stributing to death but not resu	ılting in the ur	nderlying cause giver	in Part I.		o use contribute to XNo 3 □ Pro	the cause of death?	
al Records,	The ate h	e Completed	25. Was case referred to medical					24a. Was an autopsy performed? 1 \sum Yes 2 \sum 1	prior to co death?	opsy findings available ompletion of cause of	
ion of Vital	ing Phys After this uneral dir	ToB	examiner?	ospital: 1 npatient 2 1 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. injury a Work?	at 2	(Check only one) ne 5 ☐ Residence 8d. Describe how in		fy)	
Division	ital or Attend irs after death ral Director: ,	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hos building, etc. (Specify)	")			8f. Location (Street City or Town, Sta	ate)		
	To the Hospital or Attu within 24 hours after de To the Funeral Directo completely filled in by th	Medical	29a. Certifier (Check only one) 1	sician: To the best of my knowner: On the basis of examination and manner stated.	wledge, death ion and/or inv	estigation, in my opir	nion, death occurre	d at the time, date a	nd place, and due t	o the cause(s)	
)	with Con) CR	(L.)	00+1 77	29c. License	139	Ja	Pate signed (Month,	2005	
	J	10	LITTE	PATUXENT 32 egistrar's Signat	PKW		IMBIA	, Mo			
	Sta Registr	. * sal	31. Date filed (Many Pay Year) 200	5 Been 1	× do	and o					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** 05 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Rosedale If Under 1 Year If Under 24 Hrs. Hoppital Center From Klin Squa 5. Social Security Number 213 - 64 - 861 ltimore 8. Date of Birth (Month, Day 6. Sex 1 M M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 17 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Exam are must be notified at BAUTIMORE 1 Yes 2 No MT Director 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Completed by Funeral Was Decedent Ever in U.S. Armed Forces

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White etc. 1 Never Married 2 Married 1 Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) MECH ANIC AVIOMOTIVE Illiams, Dennis 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 7.05 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee any in 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final per GI Blee Due to (or as a consequence of): **Physician** Bleed disease or condition resulting in death) Days /Medical Examiner failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit 1 + it's C the attending physician and Due t (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown à Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by Renal failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an Was an autopsy performed? 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🕎 No 1 Alnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Injury 1 Natural 1 🗌 Yes within 24 hours after death. To the Funeral Director: A investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) impleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who Franklin Ur. Jon 31. Date filed (Month, Day, Year) AN 2 0 2005 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 11:30 ₽[™] JULIA M WARREN JAN 19 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOSEPH RICHEY HOSPICE BALTIMORE N/AIf Under 1 Year If Under 24 Hrs. 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 1 F 73 Director 218-26-9487 08/08/1931 GEORGIA Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28e-f show traumatic event, the Medical Exarts or must be notified at 1 Yes 2 No Director ANNE ARUNDEL HANOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7114 WRIGHT ROAD 21076 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: BLACK ð 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH HOUSEKEEPER DOMESTIC Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi Be MOSES COBB NELLIE FEW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CARLTON E WARREN / HUSBAND 7114 WRIGHT RD, HANOVER, item 27 20c. Location - City or Town, State Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ŏ 1√2 Burial 2 □ Cremation 3 □ Removal from State

'4 □ Donation 5 □ Other (Specify) permit. Page Department Importent: if any injury or once. REST CEMETERY 1/26/05 HANOVER, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AV, BALTIMORE, Enter the disease, or complications that caused it, or hear railure. List only one cause on each the he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Betw Opset and De Immediate Cause (Final Physician disea or condition resulting in death) /Medical **Examiner** Sequentially list conditions or as a consequence of Examiner any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) Physiclan/Medical the Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed Were autopsy findings available prior to completion of cause of death?

1 \$\sum 795 2 \sum No 24a. Was an has 1 ☐ Yes 2 0 No Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Hether (Specify) 1 🗌 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospitel or Attending Division 1 Natural 5 Pending investigation 2 Accident 6 Could not Director 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerei L 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

		,	For State Registrar	State of Mary		artment of H			ene g. no. 005	01175
			1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month		3. Time of Death
	Physici /Medic		DUANE W. L	الكلاخ				JANUARY	13 2005	2:20 PM
}	Examin		4a. Facility Name (If not institution,				Location of Death	1	4c. County of Deat	
				e House		EASTO			TALBO	
	Funeral			3 4	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birti	hplace (State or Foreign untry)
	Director		212 66 2162 Usual Residence of Decedent	7	110.			12 21	1954 MA	KYLHND
	land ow		10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
	Mary First	호	MD TAI	BOT	FAST	ING				1 ☐ Yes 2 No
	r 28e	Directo	10e. Street and Number	,		10f. Zip Code		10	g. Citizen of What Co	untry?
	h witi	ai D	9200 FOX N	DEADOW 1	M.	216	100	1	MITED	STATES
	deat	Funerai	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp an. Mexican, Puert	pecify Yes or No-	14. Race - Ame Black, White	
98	or Its	y Fu	1 Never Married 2 Marrie	d 1 ⊟Yes 2 KNo If Yes, Give	1	1 ☐ Yes 2 🗙 No	Specify:	,,	Specify:	DHITE
5-0036	72 hours after death with the Maryland 'natural', or Items 23s or 28e-f show diest Exercinal be redified at	d by	3 Widowed 4 Divorced	Year or Dates:	100 000	death Havel Occur	-41			
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2121	filed within Hygiene. wher then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	REPI	AIRMA	(1	F	ELECTRO	DIJICS
	illed Hygid othar	0	17. Father's Name (First, Middle, La	ist)			18. Mother's Nan	ne (First, Middle, M	aiden Sumame)	
Maryland	Mental Mental arked o	To B	BASCOMB	WILLIS			MARY	LOU	WAGI	KD
ary	2 should and Men Is marke sumatic		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State, 2	(ip Code)
			SUE WILLIS	1SPOUSE	920	D FOX [MEADO	OLD. E	ASTON, I	ND 21601
ore	Pages 1 nent of Hi int: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		Ob. Place of Dispo cemetery, cres	sition (Name of natory or other place	را ا	Date 2	0c. Location - City or	Town, State
Ë	Pag tmen tent: jury		*4 Donation 5 ☐ Other (Spe		MOTHUL	4 GIFTS	KEG. III	2102 IF	FUNONÉ	KIND
Baltimore,	permit, Pages 1 and Department of Health Importent: If item 27 any Injury or othar tr once.		21. Signature of Fundral Service in	censee	- 22 H	Name and Address	ss of Facility REMATIC	AUR LEX	27. FAMIL	y FUNERAL
	40200		26a, Part 1, Enter the disease, or co	populications that caused the	26	O HOUNTAIN	LD. MASAN	TAMO ZII	22	Approximate
			26a. Part 1. Enter the disease, or c shock, or heart failure. List or Immediate Cause (Final	nly one cause on each line,	fr x		C a as CA		51,	Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a. Nu lagi	ter pa	, Volad (anov			5 years
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						
o,	a exec an an irial-ti		resulting in death) Last	Due to (or as a cor	nsequence of):					
8760	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Physician/Medical	•	d						<u>.</u>
9	leath certifica attending ph I for use as th	Mec	IF FEMALE:	00 - 11						
Вох	ath cultifiend	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr	Fetal death 3	Ectopic pregnancy	,		23d. Date of deli Month	very Day Year
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σ.	res that the de signed by the a be detached t		Part II. Other significant condition	s contributing to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
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Vital		0	25. Was case referred to medical				26. Place of Dea	th (Check only one		2010
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n of	Jing Ph J. After th funeral	ü	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injun Worl	y at k?	28d. Describe how	v injury occurred	
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	pital ours a arel (29a. Certifier 1 Certifying	Physician: To the best of my	knowledge death	a accurred at the time	ne, data and place	and due to the car	see/e) and manner as	etated
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	To tha Hospital or Attending Ph within 24 hours after death. To the Funarel Diractor: After th completely filled in by the funeral	Me	29b. Signature and little of certifien	C . A		29c. Lisenso	e number	1 29	d. Date signed (Month	Day Year)
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1			30. Name and address of person w		(Item 23a) (Type,	Print)	Civido #1	5 FACL	on imp 2	11001
**	1		DOLLIN	M.D. 29466	rintau	L Drive	Sull "S), cusi	JUNI Z	1401
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			State of Maryland	Department of Health and M	•	e
			1 - State Registrar	Certificate of Death	Rag. No	2005 01176
	Physici		1. Decedent's Name (First, Middle, Last)	Wober	2. Date of Death Month Da	y Year 3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	hnuary 15	: County of Death
			The Johns Hopkins lospi	ITAI BALTIMORE	CITY	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 218-53-5794 1 M 217 F 6	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) NOV 12, 19	
			Usual Residence of Decedent		NOV 12, 1:	
	show	٦		own or Location		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Director	MD Prince George Laure	el 10f. Zip Code	10g Cit	tizen of What Country?
	3a or	i Di	12950 Claxton Drive	20708		S.A.
	ams 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - American Indian, Black, White, etc.
36	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show digal Examinat must be indiffed at	by Fu	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give	1X Ves 2□ No Specific		Specify: white
21215-0036	2 hour			6a. Decedent's Usual Occupation	vadoran	White Kind of Business/Industry
212	within 72 ene. than na	Completed	(Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	ing	
	filed withi Hygiene. ither than	Соп	0 r	n/a	n/a	
Maryland	ould be fil Mental H larkad ott latic evan	Be	17. Father's Name (First, Middle, Last) John David Weber		e (First, Middle, Maiden	
Ž	should and Men Is marka	ပ		9b. Mailing Address (Street and Number or Run	nn Harringt a <i>l Route Number, Cit</i> y (
	od 2 Ith a 27 Is		John D. Weber /father	12950 Claxton Drive,		
ore,	0 0 = =		20a. Method of Disposition 20b. Place 20b. Place 20emetria 2 □ Cremation 3 □ Removal from State			ocation - City or Town, State
Baltimore,	Pag nen ant:		`4 □Donation 5 □Other (Specify) IVY	Hill Cemetery Jan 1	.9, 05 Lau	rel, Maryland
Bal	permit. Pa Dep rtmen Important: any injury		21. Signavir, of Funeral Servic Lice see	22. Name and Address of Facility Donaldson Funeral	HOme, P.A.	
	•		23a. Part1. Enter the disease, or complications that caused the death. D	313 Talbott Ave. Lo		Approximate
	Enysician		shock, or llear faylure. List only one cause on each line. Immediate Cause (Final disease or condition	A		Interval Between Onset and Deat
	/Medical Examiner		resulting in death) Due to (or as a consequent	ce in:	-	1 ruomoj
	Ladillile	<u></u>	Sequentially list conditions, if any leading to immediate	OUTIC PETITEINI	9	an dedan
11	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	- mal when the	WORK	+ 2 months
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Box	death e atter d for u	Physician/M	in the past 12 months? 1 Ves 20 No. 4 Pregnant at time of death			Month Day Year
P.O	at the de by the stached	hys	9 ☐ Unknown			
	The law requires that the tee bas been signed by thoage 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.		use contribute to the cause of death? □No 3□ Probably 4□Unknown
Sor	w require been si	etec	arost versus host direc	710	24a. Was an	24b. Were autopsy findings available
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of V	Physician: this certific ral director,	To B		Outpatient 3 DOA Other: 4 Nursing Ho	me 5 Residence	6 □Other (Specify)
o uc	ding P h. After t funera	ion:	1 Natural 5 Pending (Month, Day Year)	b. Time of 28c. Injury at 1	28d. Describe how inju	ry occurred
Division	Attanding or death. actor: After by the funer	fical	2 Accident investigation 3 Suicide 6 Could not be determined		28f. Location (Street are	nd Number or Rural Route Number,
ā	s after s after al Dira	Certification;	4 Homicide determined building, etc. (Specify)		City or Town, State	a)
	To the Hospital or Attanswithin 24 hours after deati To the Funaral Director: completely filled in by the	edical	29a. Certifier (Check only (Ch	dge, death occurred at the time, date and place, and/or investigation, in my opinion, death occurr	and due to the cause(s) ed at the time, date and) and manner as stated. d place, and due to the cause(s)
	o the lithin 2 o tha o	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		te signed (Month, Day, Year)
	⊢ s ⊢ ŏ		Struck Charles	MD NES-MI	hin	MAN IN SOM
•	1		30. Name and address of person who completed cause of death (them 23	a) (Type, Print). (1)	In action A	10 10
	Sta	l a	31. Date filed (Month, Day, Year)	MOLLE 21: 121 [V]	YIVE I	(1) DV/QXX
	Regist		31. Date filed (Month, Day, Year) JAN 2 0 2005	Specific !		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 050a M January 18, 200 4NN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Towyl, or Location of Death 4c. County of Death Examiner TORC NIA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Ye 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours -64-213 1 ☐ M 2 🗷 F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic evant, the Medical Exercise must be notified at 1XYes 2 □ No Director MARYLAN D 10e. Street and Number 10g. Citizen of What Country? "natural', or itams 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then." Elementary/Secondary (0-12) College (1-4or 5+) 12+HGRADE 17. Father's Name (First, Middle, Last) Be WILLIAM MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAMUEL R. WILLIAMS (HUSBAND) 220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State CEMETELY 01-22-05 1 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MARKEAND any injury 21. Signature of Funeral Service Licensee 22. Name and Address of Hility BROWN JR. FUNERAL HOME Jetric GLTON AVE BALTO, MD, 21217 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sila **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infriedlate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ongestion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2□ No 24a. Was an this certificate has autopsy nerformed? 1 Yes 2□ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death C eck onl one Hospital: 1 Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Diractor: 6 Could not be determined 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

DHMH 17 Rev 1/200

30. Name and address

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

32. Registrat's Signature

tho completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

			For	State of Maryland	/ Depar				ental Hy	- 3) [:-	0.1.1.77.0
			State Registrar 1. Decedent's Name (First, Middle, Lasi	41	Cert	ificate o	f Death		2. Date of De	Reg. No.	15_	01178
	Physici /Medic		I EONAR		No.				Month An wa	Day	Year	3. Time of Death 530A M
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16	Funeral	ęį.	5. Social Security Number 6. Se		st birthday)	If Under 1 Year Months Day	ar If Unde	-	8. Date of Birl	h. Year) V. Year)		lace (State or Foreign
	Director		Usual Residence of Decedent	10.00					08 . 09	1-102		MD
	Maryla a-f shov	tor	10a. State 10b. County N/A		Town or Loca						1	0d. Inside City Limits 1
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other than "naturel, or items 23c or 28a-f show may injury or other traumatic event, the Medical Examinar must be routhed at ODGs.	Funeral Director	10e. Street and Number 506 Lyndhurs	t Street		10f. Zip Code	212	29		10g. Citizen of W	/hat Cour	ntry?
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Baltimore,	permit. Pag Department Importent: I any injury o		`4 Donation 5 Other (Specify) 21. Sign ure of Feneral Service Lic 3			Name and Add			0.05			ilis, MD
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	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):	· W			F	<u></u>		Yy.
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Division	spitel or Attenous after deal ours after deal erel Director: filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stree	et, factory, offic	>e	2	Bf. Location (S City or Tov	Street and Number vn, State)	er or Rura	I Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical C	29a. Certifier 1 Certifying Phyone 2 Medical Examone)	ysician: To the best of my knowniner: On the basis of examination	ledge, death on and/or inve	occurred at the	time, date a	ind place, are	nd due to the d at the time,	cause(s) and mai	nner as st	ated. the cause(s)
	To the Hos within 24 h To the Fur completely	Mec	29b. Signature and title of certifier	and manner stated.	fund		nse number			29d. Date signed		
) Bu	(can)	MD		369	42	-	TANKE	2 14	,2005
	7		30. Name and address of person who of	, NO. 1009, f	rede	rint)	Rd.	Sale	s'mol	tarrier e ng	21	228
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	lre	P						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** ware Jale Virginia JANUARI 2005 /Medical 4a. Facility Name (If not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Examiner memorial Hospital Baltimore Union If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕶 🗲 -3988 214-64 Jamuary 16,1956 MO Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-1 show any njury or other traumatic event, the Mardical Examiner must be multilled at once. 1 Yes 2 No MD Baltmone Funeral Director 10e. Street and Number 10g. Citizen of What Country? USH Avenue Ceyworth 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban_Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewire 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumame) Holcomb Ho/comb 19a. Informant's Name/Relationship (Type, Print) Sallie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald Wane 20b. Place of Disposition (Name of cometary, crematory or other place)

Date

Date Baltmone MD SON 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Cannel Cemetery 22/05 Baltmore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Havif Close Funeral Service, P. A.
5126 Belain Road Baltimone, ND 2 21. Signature of Funeral Service Licence 4D 21206-5108 Approximate Interval Between Onset and Death 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a. END - STAGE LIVER SISEASE

Due to (or as a consequence of): disease or condition resulting in death) OVER 5 LIEAR /Medical **Examiner** Due to (or as a cons sence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit EPATOR THAL SINDROME been signed by the attending physicien and should be detached for use as the burial-trai resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 200No ours after death.

nerel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitel veithin 24 hours a To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Wall AU4176435W16021 JANUARIA 30. Na and ddress of person completed cause of death (Item 23a) (Type, Print)

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Registrar

WHOCKE WALLE

2005

31. Date filed (Modth, Day, Year)

ORIGINAL

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32. Pagistrar's Signature

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WILLIAM TE MA

			1 - For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of He	alth and Mo		ene2 0 0 !	5 01180	
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п	Funeral 5. Social Security Number 6. Sex 1 M 2 M 2 M 7 Age (In yrs. last birthday)						f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear)	Birthplace (State or Foreign	
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336	II, or	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No 3	Specify:		Specify:	Black	
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	To the within 2. To the complet	Mec	29b. Signature and title of certifier	and manner sta	2100.	29c. License nu			Date signed (Moi		
	⊢s⊢ŏ		tolor Mis			2620			JUARY 15,		
•			30. Name and address of person w		eath (Item 23a) (Type			N+4V	WHITE IS,	2000	
	3		AYODELE EMULE		UTH CATON		BACTIMO	RE MD	21229		
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	Registr	ar	JAN 2 0 2	005 Seen	I St. Ago	Marie V					

			1 - For State Registrar	State of Maryla	nd / Depa			lental Hy	-	05	01181
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			Anne Arundel Med 5. Social Security Number 6. Sex		la est blish de il	Annapo If Under 1 Year		T = -	1_	Arun	
	Funeral Director		,	7. Age (In yrs		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month Da 12/31/	r 913	COUNT	inia (State or Foreign
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	or 28)ire	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?
	ath w	ral	144 Washington Rd			21037			USA		
	er de itams	Funeral Director		12. Was Decedent Ever in the Armed Forces?	J.S. 13.	Was Decedent of I f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ice - America ack, White, e	
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Maryland 21215-0036	should be filed withir of Mental Hygiene. marked othar than imatic evant, the Mental Mental of M	Be	17. Father's Name (First, Middle, Last) Elias Zoby				18. Mother's Nam	e (First, Middle, Zegob	Maiden Suma	me)	
Ž	shoutd nd Men marke	ဥ	19a. Informant's Name/Relationship (Ty)	ne Print)	10b Mailir	a Address (Cimel	and Number or Rur			0 . 7	
⊠	d 2 stranger		Michael Joseph -				nna St; A				Code)
ē,	is 1 and Heal		20a. Method of Disposition	20b.		sition (Name of natory or other pla		Date	20c. Location		vn, State
Ē	Page nent o		1 Burial 2 Feremation 3 R				atory 1/	16/2005	Brent	wood,	MD
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or of		21. Signature of Funeral Service License	Bled		Name and Address	ensburg R	ort Line	coln Fu twood M	neral D 2072	Home 22
TO SERVICE	/Medical Examiner the bridge of the private of the	lical Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):	chemi	+ lin fa.	refron			Interval Between Onset and Death
P.O. Box 68	death certiff e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregn 1 □Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3□	Ectopic pregnancy	у			ate of deliver onth	y Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions con	stributing to death but not re-	sulting in the u	nderlying cause giv	ren in Part I.		obacco use cor ′es 2 □ No	ntribute to the	cause of death?
Records,	e law require has been sig je 2 should b	Completed		1			,0,-	24a. Was autop		Were autop	sy findings available pletion of cause of
	Th ate pag							perfor 1 ☐ Yes	med? 2 No	death?	No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Ott	26. Place of Deati	(Check only or	ne)		
of	Phys r this sral di	. To	1 Yes 2 No	1 Inpatient 2 28a. Date of Injury	ER/Outpatien 28b. Time of	t 3□ DOA Ott	4 Nursing Ho	me 5 Resid			
on	Attending F r death. actor: After by the funera	tlor	Natural 5 Pending investigation	(Month, Day Year)	Injury	Wor	k? Yes 2□No		ow injury occu	1100	
Division	or Attendiater death. Diractor: A	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, str ify)	eet, factory, office		28f. Location (S City or Tow	itreet and Num n, State)	ber or Rural	Route Number,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my kn ner: On the basis of examinand manner stated.	owledge, death ation and/or inv	occurred at the tire restigation, in my co	ne, date and place, ppinion, death occurr	and due to the c	ause(s) and m late and place,	anner as sta and due to t	ted. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		· -	29c. Licens	e number	2	29d. Date sign	ed (Month, D	ay, Year)
•			バル	>		1000	\$763:	5	اسمل	10, 2	705
	\wedge		30. Name and address of person who co	mpleted cause of death (Ite	т 23а) (Туре,			0 120 5	= 37-7-107		
	1		31. Date filed (Month, Day, Year)	2001 mec 32. Registrar's Sign	(ica)	PArkun	y thin	rpolis	mo	2140	
-	Sta Registi		JAN 2 0 200	2	L .		5				

			For State	State of Maryland	l / Depa		lealth and	Mental Hyg	iene	01100
			Registrar 1. Decedent's Name (First, Middle, Las	t)	Oe.	uncate of	Dealli	2. Date of Deat	eg. No UUJ	3. Time of Death
	Physicia		Patricia Ann Bu					Month	Day Year	
	/Medic		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Deat	January	8 2005 4c. County of Dea	12:00ÅM
	LXaiiiii	C1	11304 Garrison w				Spring		Washingto	
c	Funeral		5. Social Security Number 6. Se	7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day,	Yearl 9. Bin	thplace (State or Foreign
	Director		213-32-0032	□ M 20 X F 50	Yrs.	Months Days	Hours Will.	March 28	1948 Wasi	nington DC
and	*		Usual Residence of Decedent 10a. State 10b. County	10c, City	Town or Lo	ocation				10d. Inside City Limits
Manyli	o a ba	ō								1 Tyes X No
the	28a-	rect	Maryland Washin	gcon	Clea	r Spring		10	Og. Citizen of What Co	nuntry?
with	39 or	0	11304 Garrison W	oods Tane		2172	2			
5-0036 72 hours after death with the Maryland	ms 2	Completed by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S	. 13.	Was Decedent of H			United Sta	nican Indian,
6 after	or Ite	F	1 Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 X No		If Yes, specify Cuba 1 ☐ Yes 2 ☐ No		o Rican, etc.)	Black, Whit	e, etc. Thite
21215-0036 of within 72 hours aft	Fral.	d b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		10 105 20 140	Specify:		Specify:	
_	netr	ete	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup kind of work done	during most of wo	rking	16b. Kind of Business	Industry
121 within	then M	du	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired				
	Hygie ther int,	ပိ	17. Father's Name (First, Middle, Last)		O1	fice Adm		ne (First, Middle, A	State Corr	ections
and de be	ed o	o Be	Harold F. Blewit	F				P. Tutwe	,	
Maryland d 2 should be file	and Mental Hygiene Is marked other than eumatic event, ir e Me	ို	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street				Zip Code) 21722
Z 5	nt of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23e or 28e-1 show or other treumatic event, the Medical Examiner must be notified at		David 1. Burgan	(Husband)					ar Spring	
e 1 an	Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of	1		20c. Location - City or	
mo Page	ent o nt: If ry or		1 Surial 2 Cremation 3 :	Hemoval from State	netery, crei	natory or other place n Memoria	al Pk 1-1	12-05	Hagerstown	Maryland
Baltimore, permit. Pages 1 au	Departmer Important any injury once.		21. Signature of Funeral Service Licens		22	. Name and Addres	ss of Facility DO		Fiery Fune	
ä	Depa Impo any ir		Il Januel	O. Paulen						yland 21742
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	dications that caused the ceath.						Approximate
Ph	ysician		Immediate Cause (Final	ane cause on each line.						Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a Due to (or as a conseque	ence of):	el Con	10-			Lycan
E	kaminer			h						
D	~	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):					
60, be executed	nysician and he burial-transit	Examiner	that initiated events	c						
760,	ian a		resulting in death) Last	Due to (or as a conseque	ence of):					-
0	hysic the b	licai		d						
I Records, P.O. Box 68 The law requires that the death certifical	attending phy	by Physician/Med	IF FEMALE:							
Box auth cert	or us	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of	death 3□	Ectopic pregnancy			23d. Date of del	ivery Day Year
о. В в	ned by the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of dea 9□Unknown	ath 5∟	Other (specify)			10000	Day 10a
₽ fa	od by detac	P	Part II. Other significant conditions co	entributing to death but not result	ting in the u	nderlying cause grys	on in Part I	23e Did tob	acco use contribute to	the cause of death?
Records, he law requires t	been signed b should be deta	d by			ang ar aro u	naony ing occaso give	or are are a			obably 4 Dunknown
O. Per	been si	ete						· · ·		
3e a	has Je 2	Completed						24a. Was ar autopsy perform	prior to o	topsy findings available completion of cause of
										2 No
of Vital Physiclen: T	is certific director,	Be c	25. Was case referred to medical examiner?	Hospital:		_ Othe		th (Check only one		-
P. O.	this	. To	1 Yes 2 No	1 Inpatient 2 E	P/Outpatier 28b. Time of			ome 5 Resider 28d. Describe ho	nce 6 Other (Spec	cify)
On	th. : After thi funeral o	ţ	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	(? Yes 2 □ No		in injury occurred	
Division or Attending	after death. Director: A in by the fu	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hon	ne, farm, str			28f. Location (Str	eet and Number or Ru	ıral Route Number,
÷ 5	\$ = =	ert	4 Homicide	building, etc. (Specify)		7, 2		City or Town,		
splte	neurs nerel	aic	29a. Certifier 1 Certifying Phy	vsicien: To the best of my know	ledge, deatl	occurred at the tim	e, date and place	and due to the ca	use(s) and manner as	stated.
To the Hospitel	within 24 hours after deati To the Funerel Director: completely filled in by the	Medical Certification:	(Check only 2 Medical Exam	iner: On the basis of examination and manner stated.	on and/or in	vestigation, in my or	pinion, death occu	rred at the time, da	te and place, and due	to the cause(s)
To th	withir To th	M	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Monti	n, Day, Year)
			muchael 1 6	Milour 1	40	DL	(1667		1.11.0	5
		-	30. Name and address of person who c	ompteted cause of death (Item :	23a) (Type,		, , /		1.11.c	
5H-	10			clormade 11	110	Medied	Cuma	us the	1 crs tour	MD.
	Sta	te	31. Date filod (Month Day, Year) JAN 112	32 Benistrar's Signatu	re	/	y			
	Registr	ar	ONN III	UUD Aleen K	7. 2	restad				

			1 - For State Registrar	State of Mar		artment of lertificate of			iene2005	01183
	Physici /Medic		Decedent's Name (First, Middle, Last, Lawrence Bruce					2. Date of Death Month	1 Day 2005	3. Time of Death 12:40р м
	Examin		4a. Facility Name (If not institution, give				or Location of Death		4c. County of Death	1
			Fairhaven Reti				sville		Carrol	
	Funeral Director		5. Social Security Number 577-16-3603 Usual Residence of Decedent	7. Age (In yrs. last birthday 7 Yrs.	Months Days		8. Date of Birth (Month, Day, 11-14-		nplace (State or Foreign intry) nington, DC
	Maryland B-f show	tor	MD Carroll	1	oc. City, Town or L Sykesvi					10d. Inside City Limits 1 X Yes 2 □ No
	th with the 23e or 28	Funeral Director	10e. Street and Number 7200 Third Ave			10f. Zip Code 21784	<u> </u>	10	0g. Citizen of What Cou USA	untry?
036	o 72 hours after death with the Maryland "naturel", or Items 29e or 28e-f show culcel Examiner was be multired at	δ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spi an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
21215-0036	within 72 ho ene. than "naturi ne Medical I	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Giv.		pation during most of work ad)	ing	6b. Kind of Business/	ndustry & Loan Ass
and z	jes 1 and 2 should be fried within of Health and Mental Hygienal If Item 27 Is marked other than ", or other traumatic event, it a M.	Be	12 Years 4 17. Father's Name (First, Middle, Last) George Bryan	_Years	Lobb	oist	18. Mother's Name	e (First, Middle, M		LOGII ASS
Maryland	nd 2, should lith and Me 27 Is mark r traumation	To	19a. Informant's Name/Relationship (Ty Mary Jane W. B				and Number or Rur	al Route Number,	City or Town, State, Zi	
Baltimore,	Pages 1 ar		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other pla		Date 2	Oc. Location - City or T	own, State
Pair	permit. Pages I Department of H Important: If Ite any injury or ot once.		21. Signature of Funeral Service Licens	/ /	Ing F	2. Name and Address. Carro	ess of Facility	y Fune	ral Home,	PC
F	hysician		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	ications that caused the cause on each line.	. /	ter the mode of dy	ng, such as cardiac o	or respiratory arres	acis, Mu	Approximate Interval Between Onset and Death
ı	/Medical Examiner	-6		Due to (or as a co	consequence of):	COPD				
8/60,	cale be executed physician and the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitated events resulting in death) Last	Due to (or as a c						
P.O. Box 6	the death centify y the attending I iched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1□Live birth 2[4□Pregnant at tin 9□Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y		23d. Date of deliv Month	very Day Year
	Ine law requires that ite has been signed b bage 2 should be deta	þ	Part II. Other significant conditions con	ntributing to death but r	not resulting in the I	underlying cause gr	ven in Part I.		acco use contribute to	· /
al Heco	W	Completed						24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of 2 No
Division of Vital Records,	ang rnys h. After this funeral di	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending investigation	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Y	28b. Time of	of 28c. Inju			nce 6 Other (Speci	(5)
DIVIS	at or Attending s after death. Il Director: After d in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, st Specify)		- 0	28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
:	ne hospital in 24 hours a he Funeral D pletely filled i	edical	29a. Certifying Physical Certifying Physical Check only one)	sicien: To the best of r ner: On the basis of ex and manner stated	tamination and/or in	th occurred at the ti	me, date and place, a opinion, death occurr	and due to the cau ed at the time, dat	use(s) and manner as s te and place, and due t	stated. o the cause(s)
i	vithin 24	Σ	29b. Signature and title of certifier			29c. Licens		296	d. Date signed (Month,	Day, Year)
l			· Curs			D002	9057		1/3/05	
	Sta Registr		30. Name add person who commend and person wh			*	Third Ave	e., Syk	esville,	Md.21784

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Amended, 31, TCHD, 01/06/05, sbb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** 2005 JANUARY ISABELLE G. BEGGS 11:15AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL FUTURE CARE-CHESAPEAKE ARNOLD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 6 1914 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F Hours MARYLAND Yrs 90 Director 220-66-4793 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "naturel", or itams 23a or 28a-f show the Madical Examiner must be notified at 1 Yes 2 □ No Director CROWNSVILLE ANNE ARUNDEL MD the 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with USA 1000 TUDOR DRIVE 21032 Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: 3altimore, Maryland 21215-0020 Specify: WHITE \$ 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME permit. Pages 1 end 2 should be file.
Deportment of Health end Merrimportant: if tem 27 in any injury or myce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be THOMAS STEELE ROBINSON ATHEA GREY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 TUDOR DRIVE, CROWNSVILLE, MD 21032 FAYE H. BENT/DAUGHTER 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SHERWOOD CEMETERY 1-8-2005 SHERWOOD, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 NoHO MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificete be executed attending physician end for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or as a consequence of) use as Division of Vital Records, P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? 쥰 2 No 1 🗌 Yes 3 Probably 4 Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has been si funeral director, page 2 should I Completed 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No al or Attanding Physician: Ts efter death.
I Diractor: After this certificated in by the funeral director, pa Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Nursing Home ဥ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Teath 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural Accident 5 Pending investigation Injury 1 ☐ Yes 3 Suicide 6 Could not be determined To the Hospital or Atta within 24 hours efter de To the Funeral Directo completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier

eath (Item 23a) (Type

State Registrar ecca

Day, Year)

J

34. Date filed (Month

			1 - For State Registrar		Marylar				ealth a	and M	lental Hyg	gien Reg. No	/	5	01185
	Physici /Medic		Decedent's Name (First, Middle Joan	M.		Bush					2. Date of Dea Month January		^y 2005	ar	3. Time of Death 10:23 PM
4.	Examin		4a. Facility Name (If not institution Southern Maryla	and Hospita	1		Cli	Town, or nton r 1 Year	Location o			P	County of C	Geo	
L	Funeral Director		5. Social Security Number 578-60-7873 Usual Residence of Decedent	6. Sex 7. 1 ☐ M 2 / X F	63	last birthday) Yrs.	Months		If Under: Hours	Min.	8. Date of Birt (Month, Day 9/8/194	h y, Year L	9. Wa	Birthpt Count Shir	ace (State or Foreign ry) ngton, DC
	he Maryland 28a-f show chiffed at	ector	10a. State 10b. County Maryland PrinceGe	eorge's		ty, Town or Lo stville									od. Inside City Limits 1 ☐ Yes 2 ☒ No
	3c or 2	I Dir	10e. Street and Number 2130 Brooks Dr.					Code 747					itizen of Wha SA	t Count	ry?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 Is marked other then "neturel", or Items 23c or 28a-f show or other treumatic event, the Madical Examerations in Milled at	by Funeral Director	11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Decede Ammed Force 1 Yes 2 If Yes, Give Year or Date	∍s? DŽNo	1	Was Dece if Yes, spe 1 Yes		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)		14. Race - A Black, N Specify:	White, e	itc.
Maryland 21215-0036	filed within 72 he Hygiene. kher then "netu ant, he Medical	Completed by	15. Decedent (Specify only highest Elementary/Secondary (0·12) 12th		or 5+)	16a. Dece (Give life. Analys	kind of wo DO NOT u	al Occupa ork done d se retired	ation Juring most)	t of worki	ing	16b. F	Kind of Busin	ess/Ind	ustry
yland	d 2 should be filed within h and Mental Hygiene. 7 Is marked other then "treumatic event, the Ma	To Be C	17. Father's Name (First, Middle, Harold Bush	Last)					Marie	e Ahe					
	1 and 2 sho Health and tem 27 is m		Ann Ahern Hanson/		205	6508 E	owie D	rive S		ield,	A Route Numbe Virginia	a 2	22150		
Baltimore,	t. Pa tmen tent: ijury		20a. Method of Disposition XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	pecify)		Place of Dispo cemetery, cres dar Hill	Cemet	ther place tery	01	/10/2		Sui	cation - City tland, I		
Bal	Depar Impor		21. Signatur Funeral Serial	(be			190 (<u>Jxon</u>	Hill	Rd.	neral Ho	Hil	, P.A. L, MD		
7	Physician /Medical Examiner		23a. Park Enter the disease, or shock, or heart failure. List Immediate Cause (Finat disease or condition resulting in death)	a	as a consec	Dre	U/A			cargiac	or respiratory ar	rest,	·		Approximate Interval Between Onset and Death
8760,	cate be executed by sician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	as a consec										
687	ficate physical	edical		d											
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 202 No 9 □ Unknown		n 2 ☐ Feta it at time of d	al death 3□	Ectopic p Other (s)						23d. Date of Month		y Day Year
ords, P.	w requires that been signed b should be delt	þ	Part II. Other significant condition	ons contributing to dea	th but not res	sulting in the u	nderlying (cause give	en in Part I.						cause of death?
al Record		Completed	TackyCerce	rm			<u> </u>				24a. Was autop perfor	sy	prior deat	to com	sy findings available pletion of cause of
Vital	Physicien: this certific ral director.	To Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital:	atient 2	ER/Outpatier	nt 3□ D0	Othe			n <i>Check onl</i> o		6 □Other /	Snacihi	
ion of	Jing J. After fune		27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	g 28a. Date of (Month,		28b. Time of Injury		28c, Injury Work	at		28d. Describe h			зр в спу,	
Division	To the Hospitel or Attenc within 24 hours after death To the Funerel Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could (determined)	ined 286. Place of building	, etc. (Speci						28f. Location (S City or Tow	m, Stat	e)		
	To the Hospitel or within 24 hours after To the Funerel Director completely filled in the formulation of the	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician: To the b Examiner: On the bas and manne	is of examina	owledge, deatl ation and/or in	h occurred vestigation	at the time, in my op	e, date an pinion, deal	d place, th occurr	and due to the o ed at the time, o	cause(s date an	s) and manne d place, and	r as sta due to	ited. the cause(s)
	To the He within 24 To the Fe completel	Me	29b. Signature and title of certific				29	c. License	number			29d. Da	ate signed (N	fonth, E	Pay, Year)
			30. Name and address of person	7		- 00.1.5		504				Ja	mulla	1>	7105
K	(12)		9801 Cegagia	Ave 3-4	1 8,	lues sy	Print) Ar	asto ∫ ~	o Yaz	dani	٤ ^{M.D.}				
	Sta Regist		31. Date filed (Month, Day, Year)	22. Reg	istrar's Sign	ature	E)								

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 2005 ALPHONSO January BELL 4:56 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MAGNOLIA NURSING CENTER LANHAM PRINCE GEORGE'S | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 1930 | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | (Month, Day, Year) | 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months ty☑M 2□F 579-38-8585 74 Yrs Director Washington, DC January 30 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No MD PRINCE GEORGE'S LANHAM Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a U.S.A. 20706 6703 97th Avenue Funeral Items 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 natural', or 1 ☐ Yes 2 ☐ No Specify. Black Specify: þ 3 ☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PRINTER GOVERNMENT permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked ofth any light or other traumatic event, 90x8. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FRANCIS D. BELL LOTTIE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6603 Ferman Court Riverdale, Maryland 20737 Bell/Son Alphonso Α. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery 1/7/2005 Clinton, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AdenoCarcinous **Physician** Melastatie disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medlcal IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No he 9 Unknown 9 Unknown signed by I Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification; To Be Completed by Diabetes Mellitus 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation 24a. Was an has autopsy 2 No Coronary Atery Disease 1 Tyes 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation s after decreal Director; Alter 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral L 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neelam Ashai, MD 4410 74th Ave Landover Hills, MD 20784 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 0 6 2005 Registrar

			1 = For State Registrar		Maryland / Dep <i>Ce</i>	artment of H	leaith an Death		Reg. No.	05	01187
	Physici /Medic	an	Decedent's Name (First, Middle, ALICE VIRG		WN			2. Date of De Month	Day	Year 2005	3. Time of Death 10:47A M
	Examin		4a. Facility Name (If not institution,	•	per)	4b. City, Town, or		eath	4c. Cou	nty of Death	
			149 Seafarer			Ocean				orcest	er
	Funeral Director		5. Social Security Number 169-32-0898 Usual Residence of Decedent	6. Sex 1 □ M 2 F 7.	Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Birt (Month, Da	th y, Ye <i>ar)</i>	9. Birthp Cour	place (State or Foreign ntry)
	/land		10a. State 10b. County	-	10c. City, Town or Le	ocation				1	I Od. Inside City Limits
	a-f et	tor	MD Worce	ester	Berlin						1 ☐ Yes 2 🕇 No
	ith the	Oire	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
	ath w		149 Seafarer				311		US		
920	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural, or items 23a or 28a-f ehow or other traumatic event, the Marical Exacilizational by multified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Deceded Armed Force ad 1 Tes 2 If Yes, Give Year or Date	No No		ispanic Origin' an, Mexican, P Specify:	? (Specify Yes or No Juerto Rican, etc.)	- 14. F Spe	Race - Americ Black, White, cify:	
21215-0036	in 72 ho	Completed	15. Decedent' (Specify only highest	grade completed)	(Give	dent's Usual Occup kind of work done of DO NOT use retired	ation during most of	working	16b. Kind of	f Business/In	
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Maryland	should be filed and Mental Hyge marked othe amatic event,	To Be C	17. Father's Name (First, Middle, L James Pless	ast)				Name (First, Middle,		ame)	
ary	2 should be and Mental is marked or raumatic ev		19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Maili	ing Address (Street		r Rural Route Numbe		vn, State, Zip	Code)
Σ,	1 and 2 Health tem 27		Helen Matyas				Lane	Ocean Pin			
ore	ges 1 if itel or oth		20a. Method of Disposition **D Burial 2 Cremation	3 □Removal from St	ate -	matory`or other plac		Date		on - City or To	
Baltimore,	it. Pa rtmen rtant: njury		'4 □Donation 5 □ Other (Sp		Oxford (-6-2005		rd, PA	
Ba	permit. Pages 1 and Department of Heali important: if item 2 any injury or other ance.		Hanny le	ulerson .	1/00/0/	108 Willia	am St.	Burbage Berlin, M	1D 21	al Hor 811	m e
8760, ~	Physician and // // // // // // // // // // // // //	dicai Examiner	234 Part1. Enter the disease, or shock, or lear faildre. List of shock or learning to many learning	a. Cons Due to (or b. Cons Due to (or	acina Anthe	y DISCO	71.				Interval Between Onset and Death
.O. Box 6	the death certific y the attending p iched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ☐ Fetal death 3[nt at time of death 5[☐Ectopic pregnancy ☐ Other (specify)			1	Date of delive	ery Day Year
<u>α</u>	The law requires that the der ate has been signed by the a bage 2 should be detached fo	by	Part II. Other significant condition	ns contributing to deal	th but not resulting in the ι	underlying cause give	en in Part I.		obacco use co		ne cause of death?
Vital Records,		Completed								b. Were auto prior to con death? 1 \(\text{Yes}	psy findings available mpletion of cause of 2 No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth		Death (Check only o	ne)		Daughter's
o	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a. Date of (Month,		of 28c. Injury Work	y at	28d. Describe h		other (Specificurred	Home
Division	ai or Atte s after de si Directo ed in by th	Certification:	3 Suicide 6 Could n 4 Homicide determi	28e. Place of building	f Injury - At home, farm, st ,, etc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow	Street and Num vn, State)	mber or Rura	Il Route Number,
	To the Hospital within 24 hours a To the Funerel completely filled	Medicai	29a. Certifier 1 Certifying (Check only one)	Physician: To the be xaminer: On the bas and manne	est of my knowledge, deal is of examination and/or in r stated.	th occurred at the time envestigation, in my of	ne, date and pi pinion, death o	place, and due to the opcourred at the time,	cause(s) and date and plac	manner as si e, and due to	tated. o the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier	Malon	00	29c. License			29d. Date sig	ned (Month,	Day, Year)
	· 5		30. Name and address of person v	no completed cause	of death (Item 23a) (Type	Print)	0537		1	3 4	
	10		J. MAROSE	00 3	14 FRANKLI	N Ave	Sate	302 B	cuin	M0 2	1811
	Sta Registr		31. Date filed (Month, Day, Year) JAN 6	- 2005 32. Reg	of death (Item 23a) (Type, 12 Frnw Klu petrar's Signature	Sperte					

		1 10000 1 1	State of Maryla				•	iene e -	
		For State Registrar	State of Ividiyia		rtificate of			eg. No. 200	01188
9 10		Decedent's Name (First, Middle, Last)				200	2. Date of Dear	th	3. Time of Death
Physic /Medi		Robert Russell	Baysinger	, Jr.			January	7 4, 2005	7:45 AM
Exami		4a. Facility Name (If not institution, give str		,	4b. City, Town, o	r Location of Deat		4c. County of Dea	
		305 Decatur Avenue			Salis			Wicon	
Funeral		5. Social Security Number 6. Sex 1 🔀 1	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	Year) 9. Bit	nthplace (State or Foreign ountry)
Director	ļ	212-56-1641 Usual Residence of Decedent					February	10,1951 Ma	aryland
yland		10a. State 10b. County	10c. C	ity, Town or Lo	ocation		- -		10d. Inside City Limits
Mar Ba-fsh	tor	Maryland Wicomico	Sa	lisbury	7				1∑Yes 2 No
or 28	ire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C	ountry?
yion is 2.12.13-0000 ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f show atto event, the Modical Exercipational by notified at	Funeral Director	305 Decatur Avenue			21804			USA	
ar de Items	nue		2. Was Decedent Ever in I Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puerl	specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
Is aft	byF	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 【XDivorced	1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates:		1□ Yes 2X No	Specify:		Specify:	White
2 hou	ted	15. Decedent's Educa	ition	16a. Dece	dent's Usual Occup	pation		16b. Kind of Business	
hin 7.	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of word d)	rking		
ed will	Completed	12	<u> </u>	Gener	cal Contr			Constru	ction
be fill d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nar	me (First, Middle, I	Maiden Sumame)	
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, It also	2	Robert Russell	Baysinger	, Sr.		Betty			erry
		19a. Informant's Name/Relationship (Type						, City or Town, State,	
1 and Health tem 27		Cheryl Banks (sist		Place of Dispo	sition (Name of			Maryland 20c. Location - City or	
Pages nent of I		1 X Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)		<i>cem</i> etery, crei rson s Ce	matory or other pla		y 8, 2005	Salishur	ry, Maryland
parmit. F Departm Importar any injur		21. Signature of Funeral Service Licenses		2	2. Name and Addre	ss of Facility			
		Matte 1 Noe	user CESF						ssociation
		23a. Part1. Enter the disease, or complicion shock, or heart failure. List only one	ations that caused the dea	ath. Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Rewrit S. Due to (or as a conse	gnima	maller	commo of	NILLY E	Rmoid	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	Sinv	is ()	7.3		44
LXamille	<u></u>	Sequentially list conditions, b.	Due to (or as a conse	and the second					
ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conse	querice or).					
execu n and ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):					
cate be executed physician and the burial-transit	cail	d.							
rtifica ng ph		IF FEMALE:							
ath ce ttendi	an/	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fe		Ectopic pregnanc	у		23d. Date of de	
the all	Physician/Med	1 Yes 2 No	4☐Pregnant at time of 9☐Unknown	death 5	Other (specify)			MONTH	Day Year
w requires that the death certificate signed by the attending pt should be detached for use as it.		Part II. Other significant conditions conti	ibuting to death but not re	sulting in the u	inderlying cause giv	ven in Part I.	23e. Did tol	bacco use contribute t	to the cause of death?
requires (d by						1 🗆 Ye	es 2 No 3 P	robably 4 🖼 nknown
w rag	lete						24a. Was a	n 24b. Were a	utopsy findings available
The la te has	Completed						autops perfor	rior to death?	completion of cause of
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ding Physician: The lav h. After this certificate has funeral director, page 2:	10	1 ☐ Yes 2 ☑ No Ho		☐ ER/Outpatier	nt 3 DOA Oth	ner: 4□ Nursing H	lome 5 Aeside	ence 6 Other (Spe	əcify)
ing P	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wo		28d. Describe ho	ow injury occurred	
Attending or details. Attending or death. Fector: Attending or death.	icat	2 Accident investigation 3 Suicide 6 Could not be	280 Place of Injury At	hans 45		Yes 2 □ No	CON Landing (C)		
Or A effer a Direct by by	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	eify)	reet, ractory, office		City or Town	treet and Number or R n, State)	urai Houte Number,
spita nours neral		29a. Certifier 1 Certifying Physi	cian: To the best of my kr	nowledge, deat	h occurred at the ti	me, date and place	a, and due to the c	ause(s) and manner a	s stated.
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only 2 Medical Examine one)	er: On the basis of examinand manner stated.	nation and/or in	vestigation, in my o	opinion, death occu	urred at the time, d	ate and place, and du	e to the cause(s)
Veith To t	Σ	29b. Signature and title of certifier	112.	9	29c. Licens			9d. Date signed (Mon	
(0)		pom.	Celli 1	· ·		14314		1/5/05	
6		30. Name and address of person who com	pleted cause of death (Ite	m 23a) (Type,	Print)	st., A-1	Sal	shu. M	0 21801
S	ate	31. Date filed (Month, Day, Year)	apleted cause of death (Ite	nature	Curroll 2	7 7-1	341	- bury	/
Regis		JAN 0 6 20	05 Mague	H. A	bull				

December's Name (First, Middle) Dece				I _ State	laryland / Dep	artment of Health and I rtificate of Death			01189
MAYBORNET Frances Balker And Space I frances I fran				Registrar 1. Decedent's Name (First, Middle, Last)		Tillicate of Death		No.	3 Time of Death
Example: St. Facility Name of Foreign State S							Month	Day Year	
PENINSULA RESIDNAL MEDICAL CENTER SALESIENY WICHOID Discourage 10 - 20 - 20 - 20 - 20 - 20 - 20 - 20 -					r)	4b. City, Town, or Location of Death	printer int i	4c. County of Dea	
Second Secretary Numbers 10 or 2 or		ZAGIIII	•	PENINSULA REGIONAL MEDICAL	CENTER	SALISBURY	1	WTCOMTCO	
Uses Peaced and December Doc Common Do		Funeral		5. Social Security Number 6. Sex 7. /	ige (In yrs. last birthday		8 Date of Birth	Q Ric	thplace (State or Foreign
16th Sizes 10th County 10th Sizes 10th County 10th Sizes 10th Sizes and humber 10th Zap Code 1		Director		210-22-3411	35 Yrs.	Mortals Bays Flours Will.	5-21-1919	Pa	•
Prank Hitchens State Information Number of Plans Rough Number		and w			10c. City, Town or L	ocation			10d. Inside City Limits
Prank Hitchens State Information Number of Plans Rough Number		Maryl f sho	lor	De Sussex	Delmar				
Prank Hitchens State Information Number of Plans Rough Number		28a-	rect		Domai	10f. Zip Code	10g.	Citizen of What Co	ountry?
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Prank Hitchens State Information Number of Plans Rough Number	٥	or Ite		1 Never Married 2 Married 1 Yes 2		· · · ·	o mican, etc.)		
Prank Hitchens State Information Number of Plans Rough Number	3	urel',	d b	3 A Widowed 4 Divorced Year or Dates				Specify: W.	nite
Prank Hitchens State Information Number of Plans Rough Number	رح ح	"nat	lete	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	ident's Usual Occupation a kind of work done during most of wor DO NOT use maind)	king 16b	. Kind of Business	/Industry
Prank Hitchens State Information Number of Plans Rough Number	7	withii ene. then	dmo		r 5+)	·		ub Shop	
Present		Hygi Hygi other ent, I							
Brenda P., Willkins, daughter 36627 Bi. State Blvd. Delmar, De. 19940 20. Method of Disposton 1	<u>a</u>	lid be fental rked ic ev	OB	Frank Hitchens		May Adki	ns Hitchen	s	
Brenda P., Willkins, daughter 36627 Bi. State Blvd. Delmar, De. 19940 20. Method of Disposton 1	a _S	shou s mai		19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street and Number or Ru	ral Route Number, Cit	ty or Town, State,	Zip Code)
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Physic /Medi		William	E. Brodowski					Month	Day	Year	1:21 P
Exami		4a. Feciliy Name (# not institution: Brandywii Southern Marylan	give street and number)		4b. City, Town	n, or Location	of Death	•	4c. C	county of Deat	th
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Funeral		5. Social Security Number 220–12–9593	1XTM 2□ E	s. last birthday, 7 Yrs.	Months Da		Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birt	thplace (State or Forei
Director		Usual Residence of Decedent	7	/				Nov. 2	7, 19	27 Ma	ryland
yland Now		10a. State 10b. County	10c. C	City, Town or L	ocation						10d. Inside City Limi
a-ts	to	Maryland Princ	e Georges	Brand	lywine						1 □ Yes 2 📉 N
should be filed within 72 hours after death with the Maryland ind Mental Hygiene. s marked other than "naturel", or itams 23e or 28e-f show umatic event, the Medical Expirator mat be inclifted at	Funeral Director	10e. Street and Number			10f. Zip Cod	ie			10g. Citize	en of What Co	ountry?
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er de	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of If Yes, specify C	of Hispanic O Cuban, Mexica	rigin? (Spe an, Puerto	cify Yes or No Rican, etc.)	0- 14	 Race - Ame Black, White 	
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al Hy al Hy al Hy al Oth roant	0	17. Father's Name (First, Middle, La	*					(First, Middle		umame)	
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pernit. Pages 1 and 2 should be Department of Health and Menta Important: if item 27 is marked any injury or other traumatic sone.		19a. Informant's Name/Relationship Darlene M. Solt			ing Address (Stre						Zip Code) and 20613
l and tealth im 27 thar t					osition (Name of			Drandy ate			
Se il of the		20a. Method of Disposition 1 XBurial 2 Cremation 3	Removal from State	cemetery, cre	matory or other i	place)				ation - City or	
it. Pa rtmer rtant njury		* 4 □ Donation 5 □ Other (Spe 21. Signature) of Funeral Service Lin			theran			5, 05	Dund	alk, M	aryland
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Maria and the Control		shock, or heart failure. List or Immediate Cause (Final	nly one cause on each line.			dving, such as	s cardiac o	r respiratory a			
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			Decedent's Name (First, Middle,	Last)	L ul.				2. Date of De	-	g. 4,2005	3. Time of Death
	Physici /Medic		Donna	Roberta	E	Barnh	art		Dece In		y Year	5:07 M
1	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, To	wn, or Location of C			. County of Dea	
		•	Washington C					erstown			Washi	
	Funeral		5. Social Security Number 213 – 40 – 6859	6. Sex 7. Ag 1 ☐ M 2X☐ F	e (In yrs. Ia. 62	st birthday) Yrs.	If Under 1 Months		Min. (Month, Da	rth ay, Year)		thplace (State or Foreign puntry)
	Director	-	Usual Residence of Decedent	7,7	62	115.			Novembe	r 2,	1942 M	aryland
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Many a-f sh iffed	tor	Maryland Wash:	ington	Н	agers	stown					1 ☐XYes 2 ☐ No
	th the	lrec	10e. Street and Number				10f. Zip C	ode		10g. Cit	izen of What Co	ountry?
	23e	aic	440 West Wash	ington St	reet		2	1740			U.S.A	
	tems	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	5. 13. V	Vas Deceder Yes, specify	nt of Hispanic Origin Cuban, Mexican, P	? (Specify Yes or No querto Rican, etc.)	o-	14. Race - Ame Black, Whit	
36	s afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🛣 Divorced	ed 1 ☐ Yes 2 🔼 I If Yes, Give Year or Dates:	No	1	☐ Yes 2X	No Specify:			Specify: W	hite
21215-0036	72 hours after death with the Maryland neturel', or Items 23e or 28e-f show dical Exacinet must be notified at	edt	15. Decedent's		1	16a. Deced	ent's Usual I	Decunation		16h K	ind of Business	Andustry
715	.s .e .e	Completed	(Specify only highest		5.1)	(Give life. L	kind of work OO NOT use	done during most of retired)	working	100.11	and or business	modstry
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<u>yla</u>	should benta	2	Donald Wil		у				rgaret F			
Maryland	S a a	1 6	19a. Informant's Name/Relationshi Virginia A. Ma		+ a				or Rural Route Numb			
	1 and 2 Health Iem 27		20a. Method of Disposition	Toth Daugh		CUL coqsiC to ear	3 BUIS	st Avenue,	, North Ch			S.C. 29406
ية	0 0		1 XBurial 2 Cremation		cer	metery, cren	natory or other	ar place)	01-07-05		ocation - City or	
Baltimore,		i	4 □ Donation 5 □ Other (Sp.21. Signature of Funeral Service L		gcdai							, Maryland
Ba	permit. Departr Imports any inju		A. hoel	Krader		A)	ndrew Leet	K. Coffma	n Funeral	Hom	e, Inc.	
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	complications that cause	d the death.	Do not ente	er the mode	of dying, such as car	rdiac or respiratory a	CSTO irrest,	wn, Mar	yland 21740 Approximate
	Physician		Immediate Cause (Final	niy one caus on each ii	1				1			Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a. Ceve	a conseque	ence of):	Lav	accore	n			12
	Examiner		Samuel tinibulist over the ex-	n Myo	COYO	toal	In	accide lavetion	1			120
	p #	iner	Securitary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (r as	a conseque	ence of):						
	and P-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):						
8760,	The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial transit	cai E				01100 017.						
687	ficate physics the	ed		d								
Вох	eath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			1				23d. Date of del	livery
	death	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic preg Other (spec				Month	Day Year
P.0	at the de I by the a stached	hys	9 □ Unknown′									
	res that igned to be det	by	Part II. Other significant condition	s contributing to death b	out not result	lting in the ur	iderlying cau	se given in Part I.				the cause of death?
orc	w requir been si should	eted					_		_ 1	Yes 2	□N0 31 X (PI	obably 4 Tunknown
Records,	e taw has b	ompleted							— 24a. Was	psy	prior to	utopsy findings available completion of cause of
<u>=</u>		O							1 Yes	ormed? 2 No	death?	2 □ No
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lon	Attending or death. ector: After by the fune	ation	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga		y Year)	Injury	М	Work? 1 ☐ Yes 2 ☐ No		,		
Division	or Attending Patter death. Director: After the by the funeral	ertification:	3 Suicide 6 Could no determin	and 286. Place of In	jury - At horn tc. (Specify)	ne, farm, stre	eet, factory, o	office	28f. Location (City or To	Street an	nd Number or Ru	ural Route Number,
	tel or A	Cert		building, et	ic. (Specify)				Only or 10	wii, State	1)	
	he Hospitel or n 24 hours afte he Funerel Dir pletely filled in I	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis o and manner st	of examination	rledge, death on and/or inv	occurred at restigation, in	the time, date and p my opinion, death o	place, and due to the occurred at the time,	cause(s)	and manner as d place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier				29c. l	icense number		29d. Da	te signed (Mont	h, Day, Year)
	- 7 - 0		000	180	_		0	52323		1/	4/05	
			30. Name and address of person w	no completed cause of c	death (Item :	23а) (Туре,						
4	4-4		Dy Wasces	n 1126	Opal	Co.	urt	Hag.	11ld 21	74	2	
	Sta Registi		31. Date filed (Month Dax Year)	2005 32. Registr	rar's Slgnatu	ura G. A.	serle	1				

			1 - For State Registrar	State of Maryland		artment of H		-	giene	05	01192
		3	Decedent's Name (First, Middle, Last)	1				2. Date of De	ath		3. Time of Death
	Physici /Medic		Doris Jane	Bazemore				Januar	y 2, 20	Year 005	1:30 P ^M
	Examin		4a. Facility Name (If not institution, give	street and number)	:	4b. City, Town, or	Location of Deat	h	4c. County	of Death	
ž. ,			College View 1 5. Social Security Number 6. Securi		last histhday)		lerick	8. Date of Bir		deri	
	Funeral Director			M 2KDF 79	Yrs.	Months Days	Hours Min.		v. Year)	Coun	lace (State or Foreign htry) Sinia
			Usual Residence of Decedent						, 1725		
	arylar show	ř	10a. State 10b. County		y, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2X No
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	with 3c or		4114 Lynn Burke R	and		217	70				,
	death ms 2:	Funeral		12. Was Decedent Ever in U.S	S. 13. \	Was Decedent of Hi f Yes, specify Cuba		pecify Yes or No	United 14. Race	e - Americ	an Indian,
2	after or Ita	/Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X No If Yes, Give		r Yes, specnny Cuba I⊡ Yes 2XXXNo	in, mexican, Puer Specify:	to Hican, etc.)	Specify	ck, White,	
Ś	172 hours after death with the Marylar "natural", or itams 23c or 28e-f show alsal Ezart and mast te moithed at	d by	3 Widowed 4 Divorced	Year or Dates:						wn	ite
2	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other then "natural", or items 23c or 28e-f show avant, it a healfall Evant act must be redified at	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	(Give	lent's Usual Occupa kind of work done of DO NOT use retired	during most of wo	rking	16b. Kind of Bu	isiness/Inc	dustry
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2	e file al Hyg I othe vant,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,			
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2	12 sh h and 7 fs.m traum		19a. Informant's Name/Relationship (Ty			g Address (Street a					·
	permit. Pages I and 2 should be filed within 72 hours after death with the Maryla Department of Healust and Maralla Hygiens. Department of Healust and Maralla Hygiens. Practical It is marked other then "natural", or Itams 23c or 28e-f show any injury or other traumatic avant, Itams Marallal Evant act must be rediffed any injury or other traumatic avant, Itams Marallal Evant act must be rediffed any once.		Hannah L. Matlock 20a. Method of Disposition		4114 lace of Dispo	Lynn Bur sition (Name of natory or other place	ke Road	Monrov	La, Mary 20c. Location -		
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	permit. F Departme Importar any injur		21. Signature of Funeral Service Vicense	/ 1001		. Name and Addres		,			Maryland
ă	Depar Depar Impor any ir		Hams D.	(None	16	621 Oposs	umtown F	ike Fr	ederick,	Mar	7land 21702
	1		23a. Part 1/ Enter the disease, or complishook, or heart allure. List only or	inations that caused the doath		er the mode of dying					Approximate Interval Between
ŧ	Physician		Immediate Cause (Final disease or condition	3	TROI	18					3 4 EAC 1
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):						
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į	t the d by the ached	Physiclan/Me	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9□ Unknown							
Ď.	w requires that the death certific been signed by the attending I should be detached for use as	by P	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use contr	ibute to th	e cause of death?
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נ	has be	Completed						24a. Was autop	an 24b. W	Vere autor	osy findings available inpletion of cause of
<u> </u>	i: The								rmed?	leath?	24 No
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2	ath.	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		<br Yes 2□No				
2	or Atterderinected	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Numbern, State)	ar or Rural	Route Number,
2	pital o		Continue St.								
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Suneral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination)	sician: To the best of my knowner. On the basis of examinati and manner stated.	wledge, death ion and/or inv	occurred at the tim estigation, in my op	ne, date and place pinion, death occu	rred at the time.	cause(s) and mar date and place, a	nner as sta ind due to	ated. the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed	(Month, L	Day, Year)
1) What	U mo			11912		1/05	1200	~
-	7)		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, I	Print)		c		0	11703
			JULIO NEWCIN 31. Date filed (Month) Bax (Year) = 0.00	MD 1564 (1150610	Print) whown	PIUE	" KYEDE V	ill m	Do	11102
	Sta Registr		JAN 0 20	105 Section of the state of the	M. A.	2316					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 1, 2005 Spriggs Aloyious Baker 7:30 p /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Fort Washington Hospital Washington Prince Georges Fort 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth July 23, 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Year 1943 Maryland 1**X** M 2□ F 213-46-6784 61 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location I7 is marked other than "natural", or Itams 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Maryland Charles Waldorf XXYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Brandon Circle 20602 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No 1 Never Married Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Portzen Brothers Asphalt 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked Benjamin Harrison Baker Oueen Victoria Miles ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a 701 Brandon Circle Waldorf Maryland Pamela Baker/Wife injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Bryantown, 20a. Method of Disposition Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Important: If any injury or St. Marys Cath Ch Cem 1/7/05 Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility dessa Offer MO1323 Adams Funeral Home P.A. Aquasco, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner (or as a conseque Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) the 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 No 1 Yes 2 2 No 1 Yes Director: After this certific d in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical The Carmying Prhysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 185 225 completed cause of death (Item 23a) (Type, Print) Name and address of person wh Waldorf, MD 20404 Dr. H. Timothy Pace, M.D. 31. Date filed (Month, Day, Year) State Registrar

	5-00111	: (ollins Barnett Please	Гуре or Print in Bla				_			
11	,		For State Registrar	State of Maryland		artment of H <i>rtificate of L</i>			giene Reg. No.	4000	01194
	Physicia	20	1. Decedent's Name (First, Middle, Las					2. Date of De			3. Time of Death
	Physici /Medio	al	Alexander Collin			44 Cit. T		January	y 4,	2005	11:01 P.M
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	ryland how		10a. State 10b. County	10c. City, T	own or Lo	ocation					10d. Inside City Limits
	with the Maryland a or 28e-1 show	Director	Maryland Prince Go	eorge's Cli	intor				40. 00		1 Yes XX No
	ath with the Marylan 23a or 28e-1 show		9800 Glenview D	rive		10f. Zip Code 207	35			izen of What Co nited S	
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Maryland 2121	2 should be and Mental is marked c	ToB	Wayne Alexano	_				dy Hari			
	ss 1 and 2 should be filed wit of Health and Mental Hygiend item 27 is marked other the rother treumatic event, II.e.		19a Informant's Name/Relationship (T. Wendy Harris (mot	ther)	980	ng Address (Street a	w Drive,	Clintor	n, Ma	aryland	20735
Baltimore,	e = 5		20a. Method of Disposition 1. A Burial 2 □ Cremation 3 □ I 1. 4 □ Donation 5 □ Other (Specify,	TOTTOVAL ITOTTI STATE		osition (Name of matory or other place	1	2005		nton, Ma	
altir	in 2.5 m		21. Signature of Funeral Service Licens	600	22	ction Ceme 2. Name and Addres		Funeral			
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al R	. G T							perfo 1 X Yes	rmed?	death?	2 No
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State of Maryland / Department of Health and Mental Hygien \bigcirc \bigcirc \bigcirc Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY 7, 2005 **Physician** MICHAEL DENNIS CARNEY 11:00PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 918 ISRAEL CREEK COURT KNOXVILLE WASHINGTON Months Days Hours Min. 8. Date of Birth Month Pay, 1997 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign NEW YORK **Funeral** 1⊠M 2□F 105-30-9213 67 Yrs Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28e-1 show any injury or other traumatic event, the Modical Exampler must be nutified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No MARYLAND WASHINGTON Directo KNOXVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 918 ISRAEL CREEK COURT 21758 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No δ Specify: Specify. 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) POLICE INSPECTOR METROPOLITAN POLICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be EZRA GERALD CARNEY EMMA WINIFRED COLVIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 ISRAEL CREEK COURT, KNOXVILLE, MARYLAND EUNICE L. CARNEY, SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State MT. ZIÓN CEMETERY 1/11/2005 ROHRERSVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Simplure of Funeral Sarvis Licens 22. Name and Address of Facility 7606 OLD NATIONAL PIKE A. Zimmerman kelly BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerofic Physician 2 413 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) use as the burial-transit that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760 the attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 2 2 No of or Attending Physicien:
I after death.
I Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel c within 24 hours af To the Funerel Di filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0057101 01 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Johnson SHAH NIRMAL MD VH-1K Frederic, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 2 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Winifred Adel1 Chase Januar /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 X F Days Min. 79 YES Director 473-20-8207 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28e-f show the Medical Examiner rives be notified at MD St. Mary's Mechanicsville Funeral Direct 10e. Street and Number 10f. Zip Code

12. Was Decedent Ever in U.S. Armed Forces?

10d. Inside City Limits 1 Yes 2X No 10g. Citizen of What Country?

White

Birthplace (State or Foreign Country)

3. Time of Death

2:16 PM

1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)

11. Marital Status

28465 St. Mary's Avenue

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

20659

Administrative Assistant

1 ☐ Yes 2 X No

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Government Printing Office 18. Mother's Name (First, Middle, Maiden Sumame)

United States

Specify:

14. Race - American Indian, Black, White, etc.

8

2005

1925 Minnesota

4c. County of Death

St. Mary's

17. Father's Name (First, Middle, Last) Ferdinand Winther

David A. Goff

23a. Part1. Enter the disease, or comshock, or heart failure. List only

19a. Informant's Name/Relationship (Type, Print)

12

Grace (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code

Lawrence J. Chase, Jr. (HUSBAND) 28465 St. Mary's Avenue Mechanicsville, MD 20659 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

20b. Place of Disposition (Name of cometery, crematory or other place) Jan. 13, 2005 20c. Location - City or Town, State Brinsfield-Echols Crematory Charlotte Hall, MD

MO1095 death. Do not enter the mode of dying, such 🕦 cardiac or respiratory arrest,

22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd. Charlotte Hall, MD 20622

Immediate Cause (Final disease or condition resulting in death)

o ca Due to (or as a consequence of) Approximate Interval Between Onset and Death Mily

Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

IF FEMALE

Due	to	(or	as	a	consequence of):	

Due to (or as a consequence of)

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d Date of delivery Month Dav

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

en Sio

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

00. Did (0000)	00 000	CIDUIG TO DIO COLO	30 or dodin.
Yes	2 🗀 No	3 Probably	4 🗀 Unknow

autopsy performed? (es 25/No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case		to medical	
examiner?			
1 Tyes	2/2 No		
27. Manner of	leath		

31. Date filed (Month) Aax, Year)

1 Natural 5 Pending investigation 2 Accident 3 🗌 Suicide 6 Could not be

1 Inpatient 2 DE Outpatient 28a. Date of Injury (Month, Day Year)

32. Registrar's Signature

3 DOA 28b. Time of 28c. Injury at Work? 1 Tes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of aramination and/or massignification in my opinion death occurred at the time date and place and due to the cause(s) and manner stated.

29b. Signature and title of certifier

30. Name and address of person who combated cause of death (Item 23a) (Type, Print) c Greivi

2005

State Registrar

DHMH 17 Rev 1/2001

23a

<u>P</u>

"natural"

Pages 1 and 2 should be filment of Health and Mental H tant: If item 27 Is marked other

or other

permit. Page Department of Importent: If any injury or QDCE.

Physician

/Medical

Examiner

Physician/Medical

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Completed

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Certification:

Medical

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the attending physician

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To the Hospitel within 24 hours a To the Funeral C

the funeral director.

filled in by

Winifred

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Completed

Be

death

Baltimore, Maryland 21215-0036

ORIGINAL

24a Was an

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

		For State	State of	of Marylar	nd / Depa	artme		lealth a		ental Hy	giene	_	01197
		Registrar 1. Decedent's Name (First, Middle, I	antl			unce	ile or L	Dealli		2. Date of De	Reg. No.		0777
Physici	an									Month	Day	Year	3. Time of Death
/Medic		Angelina Mary								Janua	-	, 2005	11:15 PM
Examin	er	4a. Facility Name (If not institution, g	ive street and nu	ımber)		4b. Cit	y, Town, or	Location of	f Death		4c.	County of Dea	th
		Northampton Mand		ng Home			ederi				I	rederi	ck
Funeral		5. Social Security Number 6	Sex 1 □ M 2√€ F	7. Age (In yrs.		If Und Month	er 1 Year s Days	If Under 2 Hours	24 Hrs. Min.	B. Date of Bird (Month, Da	th y, Year)	9. Bir	thplace (State or Foreign ountry)
Director		579-14-6456	ILIM QUI	92	Yrs.					July 15		12 Was	hington, DC
pu 🖈		Usual Residence of Decedent 10a. State 10b. County		100 Ci	ty, Town or Lo	antina.							1404 1-11 01 11 11
aryla eho	_	Toa. State		100.01	ty, TOWN OF EC	ocation							10d. Inside City Limits 1 ☐ Yes 21 No
8a-1	ctc		ederick		Wall		ville						1 163 2K 140
be filed within 72 hours after death with the Maryland lad Hygiene. It Hygiene. d other than "naturel" or items 23a or 28a-f ehow event, the Madical Examiner minet be notified at	Funeral Director	10e. Street and Number				10f. 2	Zip Code				10g. Citi:	zen of What Co	ountry?
23e	Ta	8402 Cub Hunt (Court				2179	3				USA	
r dez	Ine	11. Marital Status	12. Was Dec Armed F	cedent Ever in U	J.S. 13.	Was Dec	edent of Hi	ispanic Orig	gin? (Spec	ify Yes or No ican, etc.)	-	14. Race - Ame Black, Whi	
afte or it		1 Never Married 2 Married		21 No			2. No	Specify:		,			hite
ours Fee	d by	3 X Widowed 4 ☐ Divorced	Year or I	Dates:		103	ZEFINO	ореспу.				<i>эрвспу:</i> ••	11100
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should and Men e marke		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Addre	ss (Street a	and Number	r or Rural	Route Numbe	er, City or	Town, State,	Zip Code)
and 2 ealth a m 27 io		Anthony J. Cesca	ı/ Son		8402	Cub	Hunt	Cour	t W=	lkorsu	1110	, MD 2	1703
s 1 g		20a. Method of Disposition		20b. l	Place of Dispo cemetery, crei	sition (A	lame of	. 1-	Da	te		cation - City or	
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parmit. Departr Importa				0.	F	ranc	is J.	Coll	ins E	uneral	Hon	ne Inc	WB 0.000
		23a. Part1. Enter the disease, or or	amplications that	caused the dea								er Spri	ng, MD 20901
		shock, or heart failure. List or	ly energuse on	each line.	f. Do not an	Λ	-			respiratory at	1031,		Interval Between Onset and Death
Physician		Immediate Cause (Finaf disease or condition	_a. /	aspira	trom	· Pi	1eum	nonit	His				ZAN
/Medical Examiner		resulting in death)	Due to	(or as a consec	quence of):								0
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₽ #	Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or an a consec	qu ∗ice f):								0
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n carr andin use	N N	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn		_					2	23d. Date of de	livery
leath s atte	cla	in the past 12 months? 1 □ Yes 2 No		birth 2 ☐ Feta nant at time of a		⊒Ectopic ⊒Other (pregnancy specify)					Month	Day Year
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- O O		27. Manner of Death	28a. Date	of Injury nth, Day Year)	28b. Time o	f	28c. Injury Work	y at	28	3d. Describe l	now in j un	y occurred	
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i or Attending effer death. Director: After in by the fune	ific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 28e. Plac	e of Injury - At h	ome, farm, st	reet, fact	ory, office		21				ural Route Number,
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splte		29a. Certifier Certifying	Physician: To th	e best of my kn	owledge, deat	h occurre	ed at the tim	ne, date and	d place, ar	nd due to the	cause(s)	and manner a	s stated.
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o th o th omp	Me	29b. Signature and title of certifier				2	29c. License	e number			29d. Date	e signed (Moni	th, Day, Year)
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V		30. Name and address of person w	on completed and	ISB of door !!	m 22-) /T	Drine's							
		/3	ATO I	use of death (Ite	To:	(enni)	House	· A	10	Fre	el o	ac E	Mn
CA	ate	31. Date filed (Month, Day, Year)	32	egistrar's Sinn	ature 4	/ 4	NOUN	3-0 11	me 1		ر المحادث)
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Cornell, Susan String Fack
Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		riease	State of Marylan				•		egible.	0.1.1.0.0
		For State Registrar	State of warytary	•	rtificate of L		•	Reg. No.	005	01198
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Physicia /Medica		Susan Strizack Con		_			January	y 5,	2005	12:02P M
Examine	er	4a. Facility Name (If not institution, give Union Hospital of			4b. City, Town, or E1kton	Location of Death		Cec:	ounty of Deat	h
Funeral		5. Social Security Number 6. Se	ex 7. Age (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h		hplace (State or Foreign untry)
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laryland show	}	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or L	ocation					10d. Inside City Limits
Mary e-f sh	tor	Maryland Cecil	Nort!	h East						M∑XYes 2 □ No
or 28	Directo	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Co	untry?
s 23a		102 Jethro Street	12. Was Decedent Ever in U.	S 12	21901 Was Decedent of Hi	isoppie Origin? (Sp			d Stat	
r Itam	Funeral	Marital Status Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X☐ No	3.	If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		Black, White	
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s 1 and if Health Itam 27 other tr		20a. Method of Disposition	20b. P	lace of Disp	osition (Name of matory or other place	(A)	Date	20c. Loca	ition - City or	Town, State
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28e-f show any Injury or other traumatic event, the Modest Examiner must be notified at once.		21. Signature Funda Service Lice	500		2. Name and Addres	O.	rouch Fu			
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death of attended for u	Iclan	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	I death 3	□Ectopic pregnancy □ Other (specify)			25	Month	Day Year
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	BeC	25. Was case referred to medical examiner?				26. Place of Deat			1 165	20,140
hysic this ce al dire	2	1 ☐ Yes 2 No		ER/Outpatie		4 Nursing H	ome 5 Resid			cify)
ding Phys h. After this funeral dir	tlon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	/ at k? Yes 2 □ No	28d. Describe h	now injury o	occurred	
Atten r deat ector: by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, st			28f. Location (S City or Tox		Number or Ru	ral Route Number,
tal or rs afte al Dir	Cert	4 Homicue	Building, etc. (Specif)	y) 			City or Tow	ni, State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, dea tion and/or in	th occurred at the time timestigation, in my of	ne, date and place, pinion, death occur	and due to the cred at the time,	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)
To t withi To ti	×	29b. Signature and titleoof certifier	lers MD		29c. License	9 number 9 2 3 3 2 2	_	29d. Date :	signed (Monti	h, Day, Year)
2		30. Name and address of person who S S ACHDE 31. Date filed (Month, Day, Year)	completed cause of death (Item	Verd	L St See	te 3/3,	Echtu	MI	2/92	1
Sta Registra		31. Date filed (Month, Day, Year) JAN 7 - 2005	32. Registrar's Signa	ture	W				/	

		1_ For State	State of Maryland / I	Department of Health and N	Mental Hygid	ene nn5	01100
	_	Registrer		Certificate of Death		J. No.	01133
Physi	oion	Decedent's Name (First, Middle, L.			Date of Death Month	Day Year	3. Time of Death
/Med		VIN	NCENT COLANTU	ONI	Jan. 4,	2005	2245 M
Exam		4a. Facility Name (If not institution, gi	ive street and number)	4b. City, Town, or Location of Death		4c. County of Death	h
		321A 136th St	reet	Ocean City		Worceste	or
Funera	al		Sex 7. Age (In yrs. last bii	thday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,)		hplace (State or Foreign
Directo	r	067-14-0198	1≥M 2□F 84	Yrs. Months Days Hours Min.	4-16-20		taly
ъ.		Usual Residence of Decedent					<u> </u>
larylan show		10a. State 10b. County MD Worces	10c. City, Tow				10d. Inside City Limits
e Ma	양	MD Worces	ster Ucea:	n City			1/8Yes 2 □ No
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be filed within 72 hours after death with the Maryland tal Hygiene. Ital Hygiene. In order than "natural", or Itams 23a or 28a-f show event. Its Medical Exarrane must be motified at	Funeral Director	321A 136th St	reet	21842		USA	
dea	ner	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Amer	
after or Its	T.	1 Never Married 2 Married	1 AYes 2 No		nican, etc.)	Black, White	e, etc.
al',	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 42-145	1 ☐ Yes 2 ☑ No Specify:		Specify: Wh	hite
72 hc	Completed	15. Decedent's E (Specify only highest g		Decedent's Usual Occupation	16	3b. Kind of Business/I	
hin .	를	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of work life. DO NOT use retired)	(III)		
filed within Hygiene.	Į.	, , , ,		ead set up man		Stee1	
should be filed within and Mental Hygiene. marked other than imatic evant, the Market	a)	17. Father's Name (First, Middle, Las			e (First, Middle, Ma		
ould be Mental arked o	0	Giuseppe Cola	ntuoni	Maria C	arasella	•	
2 should and Men is marke	-	19a. Informant's Name/Relationship		. Mailing Address (Street and Number or Rus		_	Zip Code)
		Sarah C. Colan		321A 136th St., O			
permit. Pages 1 and 2 Department of Health s Important: If Itam 27 is		20a. Method of Disposition	20b. Place o	f Disposition (Name of		oc. Location - City or	
Pages nent of int: If it		1 Burial 2 □ Cremation 3	Removal from State cemete	ry, crematory or other place)			
t. Partitude		`4 □Donation 5 □ Other (Spec	DU C	narles cemetery 1	_8 - 05 Fa	armingdal	le, NY
permit. Departr Imports any inj		21. Signature of Funeral Service Lice	ensee/	22. Name and Address of Facility			
4 0028	2	SMM (a	IN	Ullrich Funeral	Home Be	rlin, Mo	i
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused the death. Do y one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between
Physicia	n	Immediate Cause (Final disease or condition	mo ta:	static pro	S+1 10	nancon	Onset and Death
/Medica		resulting in death)) / (1)	I WILLI	~/Wenr
Examine	r		Due to (or as a consequence	of):	5/476	Carico	~/years
		Constally the condition	Due to (or as a consequence	of):	3/47	Carico	~/years
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uted d ansit		Cause (Disease or injury	b	01):	5/0070	Carcer	~/years
executed in and ial-transit		Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	of):	SIUR	Color	~/years
e be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events	b. Due to (or as a consequence c. Due to (or as a consequence	of):	3762	Color	~/years
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			For State	State of Marylar		ertificate of t				2005	01200
	Discortal a		Registrar 1. Decedent's Name (First, Middle, Last			runoate or i	Douin	2. Date of Dea		Year	3. Time of Death
	Physici /Medio		Eleanor	Curra	(N)				3 3	0.5	1744 M
	Examin	er	4a. Facility Name (If not institution, give	street and number)	ako	4b. City, Town, or	Location of Dea	ith	40.0	County of Deat	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs.		/) If Under 1 Year Months Days	If Under 24 Hr		h Yearl	9. Birt	hplace (State or Foreign
l.	Director		093-03-2170	DM 2×F 85	Yrs.	Months Days	Hours Mir	May 4,			necticut
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or I	_ocation					10d. Inside City Limits
	e Man	ctor	Maryland Wicomico	Sa	lisbu	CY					1 ☐ Yes 2 🔀 No
	with th	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	ountry?
	ns 23	Funeral	27118 Barwick Driv	12. Was Decedent Ever in U	J.S. 13	21801 . Was Decedent of H	ispanic Origin? (USA	4. Race - Ame	rican Indian
9	or Itan	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔼 No If Yes, Give		If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	in, Mexican, Pue Specify:	nto Rican, etc.)		Black, White	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Itams 23a or 28s-f show avant, the Medical Exerting rougher relified at	ed by	3 X Widowed 4 □ Divorced	Year or Dates:	16a Dao					Specify:	White
215	in 72 in "nai	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	(e completed) College (1-4or 5+)	(Giv	edent's Usual Occup re kind of work done o DO NOT use retired	durina most of w	orking	165. Kin	d of Business/	Industry
	filed within Hygiene. Ither than "	Com	12		Home	emaker				Domest	tic
Maryland	uld be fil Mental Hy irked oth	Be	17. Father's Name (First, Middle, Last)	De eld				ame (First, Middle,		,	
Ž	should land Ment is marked	J.	Chester A. 19a. Informant's Name/Relationship (T)	Wood (pe, Print)	19b. Mai	ling Address (Street	Ida and Number or F	Rural Route Numbe		eyer Town, State, 2	Zip Code)
	s 1 and 2 should f Health and Men itam 27 is marke other traumatic		Daphne Shreiber (grandaughter)		l8 Barwick			es.		
ore	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		Place of Disp cemetery, cr	position (Name of ematory or other place	:e)	Date	20c. Loc	cation - City or	Town, State
Baltimore,			 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 	Wi		Memorial Par		_			Maryland
Ba	permit. Departr Importa any Inju		Kosti R	Derrie CE	///	followay F 501 Snow E					ssociation and 21804
	埃		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the dea						LIGT ÅT	Approximate Interval Between
	Pnysician	8 N	Immediate Cause (Final disease or condition	PUPTURAD	SIGN	icio Dil	PRRTIC	MLITIS	ς		Onset and Death MONTH
	/Medical Examiner		resulting in death)	ABDOMI		ADC	CRSS				IMONTH
		iner	if any, leading to immediate	Due to (or as a conse	quence of):						77.00
	be executed sician and buriat-transif	Exami	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CONGEST		- HEAR	TFA	HLURA	<u> </u>		5 YRARS
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit			Due to (or as a conse	quence or):						
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Вох	eath certific attending p	Physician/M	230. Was decedent pregnant	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	al death 3	Ectopic pregnancy			2	3d. Date of deli Month	ivery Day Year
0.	it fhe der by the a tached f	yslc	in the past 12 months? 1 ☐ Yes 2 Mo 9 ☐ Unknown	4∏Pregnant at time of 9☐ Unknown	death 5	Other (specify)				Mondi	Day real
Δ.	es that figned by	by Ph	Part II. Dther significant conditions co	ntributing to death but not re	sulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco us	se contribute to	the cause of death?
Vital Records,	w require been sig should b							1 🗆 Y	'es 2	No 3□Pr	obably 4 DUnknown
Sec.	e faw r has be	Completed			···			24a. Was autop	sy	prior to c	itopsy findings available completion of cause of
alF		e Cor	25. Was case referred to medical					1 Tes	2009 2000	death? 1 ☐ Yes	2 No
	Physician: this certifica	O B	examiner?	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpati	ent 3 DOA Oth	or:	eath (Check only on Home 5 - Resid	1	Ather (Spec	city) HOSPICE
n of	ng Ph áter th ineral	on: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Injur		28d. Describe h			
Division	or Attanding Fatter death. Diractor: After din by the funeral	icatl	Z☐ Accident investigation 3☐ Suicide 6☐ Could not be	28e. Place of Injury - At I	nome form		Yes 2□No	29f Location /6	etroot one	(Alumbar as Ou	ıral Route Number,
Div	spital or A ours after naral Dirac filled in by	Certification:	4 Homicide determined	building, etc. (Spec	ify)	street, factory, office		City or Tow	m, State)	I IVUITID O F OF MU	irai Houle ivumber,
	Fur Bly	Medical	29a. Certifier Certifying Phy (Check only one)	sician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, dea	ath occurred at the tin investigation, in my o	ne, date and place pinion, death occ	ce, and due to the courred at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier			29c. Licens			29d. Date	signed (Month	h, Day, Year)
	108		1-5 Can	wert	wo	Doo	5241	0	0	1/4/0	5
	30		30. Name and address of person who co		m 23a) (Typi №0 <i>WH</i>	ill RA	. 84	LISBUR		ws.	21801
E	Sta		31. Date filed (Month, Day, Year)	32. sistrar's Sign	ature				_/		, , ,
100	Regist	rar	JAN 05 21	JUJ Malera	11.	Iraeli)					

			For	State of	Maryland		artmen	t of H	ealth a		ental Hy		2 n n c	0100	
			1 - State Registrar			Ce	rtificate	e of L	Death			Reg. No	- 00 t	0120	
п	Physici	an	Decedent's Name (First, Middle, in the control of the control	,							2. Date of De Month	Da	Year		
	/Medic Examir		Irvine Lee CLIN 4a. Facility Name (If not institution, of		ber)		4h City	Town or	Location of		anua		County of De		
	- Xamiir	ięr	Washington Coun						ersto				Washing		
	Funeral			. Sex 7	. Age (In yrs. la		If Under Months		If Under Hours		8. Date of Bir (Month, Da			rthplace (State or Fore	ign
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	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation							10d. Inside City Lim	its
	Mary I-f sh	ţō	Maryland Washi	neton	TA	lillia	menor	+						1∭Yes 2⊡t	No
	death with the Maryland ms 23a or 28a-f show r must be notified at	Funeral Director	10e. Street and Number 154 N. Artizan			<u> </u>	10f. Zip					10g. Ci	tizen of What C	country?	
	23a	rai	Williamsport Nu	rsing Hom				217					S.A.		
	er de	une	11. Marital Status	12. Was Deced	es?	13.	Was Deced If Yes, spec	ent of Hi	spanic Ori n, Mexican	gin? (Spec i, Puerto R	ify Yes or No ican, etc.)	o-	14. Race - Am Black, Wh		
36	urs aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	ty⊡Yes 2 If Yes, Give Year or Dat			1 ☐ Yes	2 ∑ No	Specify:				Specify:	1. • A	
5-0036	72 hours after natural', or ite iteal Exaculue	ted	15. Decedent's	Education	w.w.	16a. Dece	dent's Usua	I Occupa	ation	a d considera		16b. K	(ind of Busines	hite s/Industry	_
21	within 7 ene. than "r	Completed	Elementary/Secondary (0-12)	College (1-4	lor 5+)	life.	kind of wor DO NOT us	e retired))	or working	g		aryland		
121	filed with Hygiene Ither tha		12 17. Father's Name (First, Middle, La	11		Corr	ectio	nal_			(First, Middle			nal Office	
anc	ould be fi Mental H arked ot atic ever	Be													
Maryland	2 should and Men is marke aumatic	2	Robert Joseph C 19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a			gdelen Route Numb		or Town, State,	Zip Code)	
	alth al		Leisa M. Thomas	- Daught	er		0 Poi						m. Md.		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-1 show mith jointy or other traumatic event, the Medical Examinat must be inclined at ange.		20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3	Domewal from St		ace of Dispo	sition (Nan	ne of	- 1	Da			ocation - City o		
Ë	Pag ment ant: i		'4 □Donation 5 □Other (Spe		- 1	adfor	ding	Ceme	tery	1/7	/05	Hag	erstown	, Maryland	
Salt	permit. Pag Department Important: I any Injury o		21. Signature of Euneral Service Lie	ensee	,	22	2. Name an	d Addres	s of Facilit	y M:	innich	Fun	eral Ho	ome	
	70 E 8 0		23a. Part1. Enter the disease, or co	1/1/6	MUL								wn, Md.		
	= 1		shock, or heart failure. List or Immediate Cause (Final	ly one cause on each	ch line.		1	e or ayını	g, such as	cargiac or	respiratory a	irrest,		Approximate Interval Between Onset and Death	
	Pnysician /Medical		disease or condition resulting in death)		MMO									I wo week	K
	Examiner		0	Se	1528	•								Two WEEL	18.
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury that intended each	Due to	as a conseque	2	1							IN WEEL	
	be executed ician and burial-transil	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	r as a conseque	Tau	une	ji.						ynknom	2
1760,	cate be executed oblysician and the burial-transit	icai E		200	alul	ese	lure	ell	fus	,				years.	
99	ificate g phys			d.			7.							7.0	1-100
Box	leath certifica attending ph i for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnan h 2 □ Fetal o		JEctopic pro						23d. Date of de	elivery	
	e deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nt at time of dea		Other (spe						Month	Day Year	
P.0	The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the	Phy	9 Unknown Part II. Other significant conditions			ting in the u	nderhing co	ause dive	n in Part I		23e Did t	obacco	use contribute t	o the cause of death?	
Records,	signe d be d	d by	Var	unson	s Drs	ian		1030 9140	ni iii r aiti.			Yes 2		robably 4 Nnknow	٧n
cor	w requir been si should	iete	He	merter	rein						24a. Was	an	24b Were a	utopsy findings availab	le.
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Vital		BeC	25. Was case referred to medical	and the	unei	7 10	280			of Death	1 ☐ Yes Check only o		1 \ Ye	s 2 No	_
of V	hysician: his certific I director,	To	examiner? 1 Yes 2 No	Hospital: 1 XIng		R/Outpatier			4 INU	rsing Hom	e 5 □ R <i>e</i> si	dence	6 □Other (Spe	ecify)	
n c	Attending Physician: r death. sctor: After this certification of the funeral director.	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury		Bc. Injury Work			d. Describe	how inju	ry occurred		
Division	death. ctor: Al	icat	2 Accident investigat 3 Suicide 6 Could no	be 200 Place o	f Injury - At hon	ne farm str	M factors		/es 2 □ l		of Location /	Street ar	nd Number or E	ural Route Number,	_
Ο̈́	after after Direct	Certification:	4 ☐ Homicide determine	building	, etc. (Specify)	10, 141111, 311	eer, ractory	, onice		20	City or To	wn, State	e)	urar ricul o ivamber,	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier Certifying	Physician: To the b	est of my know	ledge, deatl	h occurr <i>e</i> d a	at the tim	e, date an	d place, ar	d due to the	cause(s) and manner a	s stated.	
	To the Ho within 24 To the Fu	Medical	one)	aminer: On the bas and manne	r stated.										
	To To	2	29b. Signature and title of certifier	Sun	7		290.	License	number	196		29d. Da	te signed (Mon	th, Day, Year)	
				4	-			9	777	, , _		JUN	, 2, 2		Ð.,
1	5H-12+1	1	30. Name and address of person when the street of the stre	completed cause	of death (Item :	23a) (Type.	Print)(a	ph	ans	Rd	132	ons	boro	MO 21213	
0	Sta	ate	31. Date filed (Month, Day), Year,	2005 32.9%	gistrar's Signatu	ıre	,	1 1							-
6	Regist			1	gistrar's Signatu	9. John	whe								

State of Maryland / Department of Health and Mental Hygiene) = For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** John Alfred Davies Jr. Jan 6 2005 /Medical 6:40PM4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 270 South Potomac St. Washington County Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months 1**X** M 2□ F 73 Yrs. Director 218-24-8842 Nov 11, 1931 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits itam 27 is marked other than "natural", or itams 23a or 28a-f ahov other traumatic event, the Medical Exantinar must be notified at Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 270 South Potomac St. 21740 United States death 12. Was Decedent Ever in U.S.
Acmed Forces?
12. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or ita 1 Never Married 2 Married 4-9-1953 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: þ Specify: White 3 Widowed 4 Divorced Be Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Circuit Court Administrator | State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Alfred Davies Sr. Frances Rohrer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
270 South Potomac Street Hagerstown Maryland 21740 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st. Department of Health and Important: If itam 27 Is many injury or other traum Susan A. Davies 20a. Method of Disposition 20b. Pface of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Daurial 2 Cremation 3 Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery Jan 10 2005 Hagerstown Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 avu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final **Physician** 2 1/2 year LUN resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the l IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 No To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Certification: 28c. Injury at Work? Injury 1 Matural 5 Pending death. М 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after deatl a Funarai Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cai (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) McCor 11/10 (hory vs 31. Date filed (Month) PANY ofr) 1 2005 32. Registrar's Signature State Registrar

Charles Draper

akuluk 242 Division of Vital Records, P.O. Box 68760,

			1- Registrar Amend Item 24a per Verb., 684 per Cerb.		•	ne 2005	01203
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last) Charles Fletcher Draper 4a. Facility Name (If not institution, give street and number) Memory Hospital	4b. City, Town, or Location of Death	January	3, 2005 4c. County of Death	h
	Funeral Director		5. Social Security Number 200–28–4843 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 7. Tres.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Sept 4, 19	r) Co.	nplace (State or Foreign untry) yland
36	s 1 end 2 should be filed within 72 hours after deeth with the Marylend f Heelth and Mental Hygiene. Item 27 is marked other than "natural", or Iteme 23a or 28e-f ehow other treumatic event, the Madical Examinat must be notified at	by Funeral Director	10a. State 10b. County 10c. City, Town or Lot Maryland Caroline 12498 Ki 10e. Street and Number 12498 Kibler Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 37 No	bler Road Greens 10f. Zip Code 21639 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	10g. (Citizen of What Co USA 14. Race - Ame Black, White Specify:	ncan Indian, a, etc.
121215-0036	lled within 72 hours lygiene. her than "natural" nt, the Medical Ex	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farm	dent's Usual Occupation kind of work done during most of worki DO NOT use retired) er	Da	Kind of Business/	
Maryland	d 2 should be filed within h and Mental Hygiene. 7 is marked other than "Ireumatic event, the Mac	To Be	17. Father's Name (First, Middle, Last) Charles Henry Draper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin		Walls Dr	aper	in Code)
	jes 1 end 2 s t of Heelth an If Item 27 is or other treu		John Draper/ son 1250	O Kibler Road Gree	nsboro, M		21639
Baltimore,	permit. Pages 'Depertment of h Importent: If ite any injury or of		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22	oro Cemetery Jan 2. Name and Address of Facility	-		
			23a. Part1. Enfer the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	leegle and Helfenb O Box 160 Greensbo er the mode of dying, such as cardiac o	ein Funera ero, MD 210 or respiratory arrest,	al Home,	PA Approximate Interval Between Onset and Death
760,	/Medical Examiner /Medical Exam	cai Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	e anewysm s	ngrae	4	I
	ne deeth certifics the ettending pl hed for use as t	Physician/Medi		□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
rds, P.	w requires thet the bean signed by should be detact	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	_	the cause of death?
l Records,	: The law re cete hes be . page 2 sho	Completed			24a. Was an autopsy performed?	prior to c	topsy findings available ompletion of cause of
Division of Vital	ending Physician: The eath. or: After this certificete h the funeral director, page	Certification; To Be	25. Was case referred to medical examiner? 1		n (Check only one) me 5 ☐ Residence 28d. Describe how inj		ify)
DIVI	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funers		4 Homicide determined 28e. Place of Injury - At home, farm, str		28f. Location (Street a City or Town, Sta	116)	
	o the Hos ithin 24 ho o the Fun ompletely f	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deatled the properties of examination and/or in and manner stated.	vestigation, in my opinion, death occurred 29c. License number	ed at the time, date a	(s) and manner as nd place, and due place and due place and due place and due place are also between the place and place are and place are also between the place are are are also between the place are also bear are also between the place are also between the place are also	to the cause(s)
	~ s ⊢ ŏ		30. Name and address of person who completed cause of death (Item 23a) (Type,	D 0053255		5/05	
	Sta	te.	Mellade Butter als Sloomings	halo Are Feder	ender	g an	1632
	Registr		JAN 1 0 2005 Jane 15 /	sale			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DEAN Year **Physician** LUTHER FRANKLIN JANUARY 5:40 P M 06 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MARYS LEONARDTOWN ST- MARYS 57 HOSPITAL 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 12 M 2 □ F 579-18-8173 86°rs Director 11-20-1918 Maryland Usual Residence of Decedent Pages 1 and 2 should be tiled within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23s or 28e-f ahow ury or other traumatic avent. It is Medical Evarinter mant be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo MD St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24603 Hollywood Road 20636 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 XYes 2 No If Yes, Give Year or Dates: 1941-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced 1943 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Painter U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Luther Franklin Dean, Sr. Lillian Grace Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other traugonce. 24603 Hollywood Road, Hollywood, MD 20636 of Disposition (Name of 20c. Location - City or Town, State Fay Dean/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Joy Chapel Cemetery 1-11-05 Hollywood, Maryland 21. Signature of Emieral Se 22. Name and Address of Facility Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650 Edward N. Brinsfield, Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RUPTURED ABDOMINAL ADRTIC ANGURYSM **Physician** HOURS /Medical Due to (or as a consequence of): Examiner BDOMINAL ADRTIC ANEURYSM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine the attending physicien and the for use as the burial-transit The law requires that the death certificate be executed ATHEROSCLEROSIS resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2)X No Completed 1 Tes 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 No 1 ☐ Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Suppatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 2 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Alatural Injun 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after use... To the Funerel Director: / 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) SAD JANUARY 06, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL, LEONALD TOWN, MD ND HARVEY MARYS 57 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

		4	State	State of Maryland		artment of H		-		2005	0.1	005
			Registrer		Cer	unicate or i	Jean	2. Date of De	Reg. No.	-000	3 Time	of Death
e	Physicia		Decedent's Name (First, Middle, Last)	T) en a la			Month	Day	Year		
	/Medic	al -	Doris E.		rexhag		Location of Death	January		2005 County of Death	8:30	РМ
	Examin	er	4a. Facility Name (If not institution, give st	reet and number)				ı				
			905 Shelby Drive 5. Social Security Number 6. Sex	7. Age (In yrs. I	ast hirthday)	Oxon Hi	I I Under 24 Hrs.	8. Date of Bir	th	ince Ge		e or Foreign
	Funeral Director			M 20x 74	Yrs.	Months Days	Hours Min.	Sept. 20	(V, Year)	O New	York	o or r orongin
		1	Usual Residence of Decedent					Берет-				
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside	City Limits
	Mar 9-f	io	Maryland Prince Ge	orges Oxo	n Hill						1 🗆 Y	es 2 XNo
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	intry?	
	th wil	3	905 Shelby Drive			2074	5		U	SA		
Maryland 21215-0036	d within 72 hours after death with the Maryland jiene. rithan "natural", or items 23a or 28e-f ehow tra Medical Evaninat must be notified at	by Funeral I	11. Marital Status 1: 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 猶No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ॲ No	ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		4. Race - Amer Black, White Specify: Whi	, etc.	,
Ŏ	2 ho	ted	15. Decedent's Educ	ation (16a. Deced	dent's Usual Occup	ation	rkina	16b. Kin	d of Business/I	ndustry	
215	- 2	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired	during most or wor d)	King				
21	filed within Hygiene. other than	Completed	12		Cash	nier			Reta	ail		
פ	be filed stal Hygi of other event, I	ВеС	17. Father's Name (First, Middle, Last)	21	,			ne (First, Middle,				
<u>/a</u>	should be and Mental marked o	2	Edward	Sha	rkey		Frances	Моє	etta	Dri	ver	
lan	0 0 0		19a. Informant's Name/Relationship (Typ			ng Address (Street			-		ip Code)	
2	other tr		Eileen F. Bamba /		-	Woodcres					C+-+-	
ore	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re			natory or other place		372005		cation - City or I		•
Ë	tment tent:		* 4 □ Donation 5 □ Other (Specify)			n Nationa				ngton,	V A	
Baltimore,	permit. Page Department Importent: II any injury o		21. Signature uneral Service Cense	elis	6.	eorge Apre 160 Oxon	Hill Rd.	, Oxon F	lill,	P.A. MD 207	45	
			23a. Party Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death e cause on each line.	n. Do not ent	ter the mode of dyir	ng, such as cardia	or respiratory a	rrest,		Approxi	Between
-	Pnysician	11	Immediate Cause (Final disease or condition		leart	Disease					Onset al	nd Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):					1		
Н	Examiner		Sequentially list conditions, if any, leading to immediate									
	sit s	Examine	if any, leading to immediate cause. Enter Underlying Cause (bisease or figury) that initiated events c.	Due to (or as a conseq	uence or):							
	cate be executed physicien and the burial-transit	хап	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):			-				
8760,	be e iicien buria	a E										
687	icate phys s the	edical										
O. Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 (\$\frac{1}{2}\$No 9 □ Unknown	ac. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	I death 3	Ectopic pregnanc ☐ Other (specify)	y		2	3d. Date of deli Month	very Day	Year
<u>a</u> .	that red b	y Pt	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	ınderlying cause giv	ven in Part I.	23e. Did	tobacco us	se contribute to	the cause	of death?
Records,	quires n sign	d by	Mitral Valve Surg	ery, Atrial H	ibril	lation		1 🗆	Yes 2	□No 3□Pro	obably 4	∑ Unknown
00	w requir s been si should	Completed						24a. Was		24b. Were au	topsy findir	ngs available
Re	The law cate has	E						auto perfe	omed? 2 No	death?	2 No	of cause of
Vital		BeC	25. Was case referred to medical				26. Place of De	ath (Check only		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20.10	
>	S 0 15	To B	examiner? 1 X Yes 2 □ No	ospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Ott	200	Home 5X Res		Other (Spec	ufy)	
of			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	of 28c. Inju	ry at	28d. Describe	how injury	occurred		
Ö	Attending r death. ector: After by the fune	atlo	1 ♠ Natural 5 Pending 2 Accident investigation	(, 5.5)	,,		Yes 2 □ No					
Division	i or Attendenter deatl	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif		reet, factory, office			(Street and wn, State)	d Number or Ru)	ral Route A	/u <i>mber</i> ,
	rs efter or rei Dir	Cer				<u> </u>						
	To the Hospitel or Attent within 24 hours effer deal To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1 Certifying Physical Exemination (Check only one)	sicien: To the best of my kno ner: On the basis of examina and manner stated.	wledge, deal ition and/or in	th occurred at the ti nvestigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time	cause(s) , date and	and manner as place, and due	stated. to the caus	se(s)
	To the within 2 To the comple	₩ W	29b. Signature and title of certifier	1		29c. Licen	se number		29d. Date	e signed (Month	n, Day, Yea	r)
	H S H O		> John N. I	lan Jam M	11	D:	30583			6/0	5	
0	(12)		30. Name a ddress of person who co	mpleted cause of death (Iter			, - 0 -		- 1	- 1		
_	10		11.00	. 3508 Old S			Suitlan	d, MD 20	0746			
	St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	R.						

			State of Maryland / Department of State of Maryland / Department of State Amend Item 10a-f per fh G839 1-28-05 to Registrar	f Health and Mer	ntal Hygien	^e 2005	01206
			1. Decedent's Name (First, Middle, Last)		Reg. N Date of Death	0.	3. Time of Death
	Physicia		Martha Montgomery Dilks	Te	Month Danuary 4.	ay Year 2005	7:02 P ^M
	/Medic Examin			m, or Location of Death		c. County of Death	
			Union Hospital of Cecil County Elkton		С	ecil	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye Months Da	ear If Under 24 Hrs. 8. ays Hours Min.	Date of Birth (Month, Day, Year	9. Birth	place (State or Foreign intry)
	Director	-	213 46 2648 78 Yrs.		ov. 10,19		sylvania
	and and	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Napl Florida Collier South Napl	1			10d. Inside City Limits
	Mary -f sh	ţō	Florida Collier South Napl	Les			Yes No
	r 28a	Funeral Director	10e. Street and Number 10f. Zip Coe	 ₹⁄,102	10g. C	itizen of What Cou	intry?
	th wit	a D	2020 6th St. 529 Dilks Lane 21921	74102	Uni	ted State	es
	r dea	ne.	1.1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent If Yes, specify (of Hispanic Origin? (Specif Cuban, Mexican, Puerto Ric	y Yes or No-	14. Race - Ameri Black, White	
36	hours after death with the Maryland lurs!', or ttems 23s or 28s-f show al Examinar must be notilied at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2 🛣 Six Operator Dates:	No Specify:		Specify: -	
21215-0036	hour	edt	15. Decedent's Education 16a. Decedent's Usual Oc	ccupation	16h	Kind of Business/Ir	ite
15	in 72 n "nat Wedic	Completed	(Specify only highest grade completed) (Give kind of work do	one during most of working	100.	Till of Dusilles set	iddally
21	d within giene. er than "	E O	Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Homemaker		Own	Home	
p	al Hygie d other	Be (17. Father's Name (First, Middle, Last)	18. Mother's Name (F	First, Middle, Maide	n Sumame)	
yla	should be t ind Mental I s marked o umatic eve	ပ္	Kingsley Montgomery	Alice Timm	nons		
			A) and	reet and Number or Rural R	24 19004	in esteur	
ď.	of Health		William Dilks, Jr/Son 2020 6th Str 20a. Method of Disposition (Name o	reet, South Na	0 000 1	Langting City of T	Chata
Baltimore,	permit. Pages of the Department of the Important: If its any injury or of once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Januar	y 8, News	ark, Dela	WII, State
臣	artme ortani injury	ı					iware
Ba	permi Depa Impo any it			th Main Stree	ch Funer		vland 21001
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of			Last, mar	Approximate
i i	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a METASTATIC UTE.	RINE CA	NICED		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. METASTATIC UTE. Due to (or as a consequence of):	RIVE CA	IVEER		Zmonths
	Examiner		Sequentially list conditions b.				
	ad sit	lnei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	be executed siclan and burial-transit	Examine	resulting in death) Last Due to (or as a consequence of):				
8760,	be e siclan buria						
9	The law requires that the death certificate to has been signed by the attending physicage 2 should be detached for use as the	Physician/Medical	0.				
Вох	eath certific attending pl for use as t	N/W	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnance			23d. Date of deliv	very
	death	sicla	in the past 12 months? 1 □ Yes 2 □ No 4 □ Pregnant at time of death 5 □ Other (specify			Month	Day Year
P.O	at the de i by the s stached	Phys	3 Unknown				
	res thar signed I be det	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause OBSTRUCTWE UROPATHY	a given in Part I.	23e. Did tobacco		the cause of death?
of Vital Records,	w requir been si should I	Completed					
Rec	has l	mp	RENAL FAILURE		24a. Was an autopsy performed?	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
B		e Co	25. Was case referred to medical		1□ Yes 2☑N		2 DHO
Š	ysicia is cert directe	o B	examiner? 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA	26. Place of Death (Cother:		6 Other (See	i4.1
10	ding Phy h. After thi funeral	n:T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c.		d. Describe how inj		ny)
jo	Mtendin death. ctor: Afr y the fur	atlo	2 Accident investigation M	1 ☐ Yes 2 ☐ No			
Division	or Attenuater deat Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, off building, etc. (Specify)	fice 28f	Location (Street a City or Town, Sta	and Number or Rur te)	ral Route Number,
	urs at urs at srai D						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) 29a Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the particular of the passis of examination and/or investigation, in and manner stated.	ne time, date and place, and my opinion, death occurred	due to the cause(at the time, date a	s) and manner as s nd place, and due f	stated. to the cause(s)
	Vithin Fo the	Me	29b. Signature and title of certifier 26.	cense number	29d. D	ate signed (Month,	. Day, Year)
)	. , , , ,		Maylund MD Do	5051197	JAN	JUARY 6	,2005
	20		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				- 1 10 - 10 -
	U			TREET, #	320, WI	LMING7	ION DE 19801
	Sta Registi		31. Date filed (Month, Day, Year) JAN 7 - 2005 32. Registrar's Signature				
	negisti	uı	SHILL FOOD PROPERTY OF PARTY				

			State of Maryland / Department of Health and		_	
		-	1- State Registrar Certificate of Death	Reg. N	/11115	01207
			Hegistrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death	10.	3. Time of Death
	Physicia		William Davis	Month	year Year	1950pm
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea		c. County of Death	
			Dorchester General Hospital Cambrid	ge	Dorche	ester
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Ha	(Month, Day, Yea	9. Birthp	lace (State or Foreign
	Director		Usual Residence of Decedent	Jan. 10,1	931 Ma	ryland
	land		10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
	Mary -f sh	to	MD Dorchester Vienna			1 ☐ Yes 2 12 No
3	r 28a	rec	10e. Street and Number 10f. Zip Code	10g. C	Citizen of What Cour	ntry?
3	h with	Funeral Director	P.O.BOX 31 21869		USA	
0	ems	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Americ Black, White,	
36	ours after death with the Marylar rel', or Items 23e or 28e-f show Examiner court be notified at	by Fu	1 Never Married 2 Married 1 1 Yes 2 No Specify:	,		
215-0036	within 72 hours after death with the Maryland ene. then "naturel", or Items 23e or 28a-f show the Madical Examinar court be notified at		Tear or Dates: 1935	164	DIC	ack
7	in 72	Completed	(Specify only highest grade completed) (Give kind of work done during most of wo	orking 166.	Kind of Business/In-	bustry
212	with liene.	mo	Elementary/Secondary (0-12) College (1-4or 5+) Processing Line W	lorker Pa	ultryI	industry
	should be filed within 72 hc nd Mental Hygiene. marked other then "natu imatic event, the Medical	BeC	40 At-4- At 1	ame (First, Middle, Maide	en Sumame)	
<u>a</u>	Mental Mental arked c	To B	Charles Davis May	y Jack	< 50 n	
Maryland	s 1 and 2 should if Health and Men Item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	Rural Route Number, City	or Town, State, Zip	Code)
-	1 and 2 Health 6m 27 I		Sharon Rideout 1025-Cosby Ave.			21613
altimore,	0 0		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place)	1	Logition - City or To	1
Ë	Pagentent:		'4 Donation 5 Other (Specify) Veterans Cemetery!	10/05 H	urlock	Maryland
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Henry Funera	1 Home, P. A		
	00 = 6 OI		TAIMOLLE (", SHALL! EINMING TONG	st (ausha:	dge, MD	
			23a. Part / Enter the disease, or complications that caused the dead. Do not enter the mode of dying, such as cardia shook, or heart failure. List only one cause on each line.	ac or respiratory arrest,	• /	Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death) a. Ceretro VASCUIM Acudui	+		10 dry=
	/Medical Examiner		Due to (or as a consequence of):			5 yo.
		70	Sequentially list conditions, b. Due 15 for an a confidence of			2 7/15
	nsit	n ji	Sequentially list conditions, if any, leading to incrediate cause. Enter Underlying Cause (Disease or injury that initiated events			
Ć,	execu n and ial-tra	Examiner	resulting in death) Last Due to (or as a consequence of):			
760	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	cal	d.			
9	tifical ng phy as th					-
Вох	th cer endir r use	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of delive	,
	deal	sicia	in the past 12 months? 1		Month	Day Year
P.0	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	22a Did tobase	o use contribute to the	a anusa of death?
S	res the signe					ably 4 Unknown
Records,	requ	Completed by				
3ec	has I	mpl		24a. Was an autopsy performed?	prior to condeath?	psy findings available mpletion of cause of
a	n: Th licate r, pag			1□ Yes 2□1		21 No
Vital	certi	o Be	examiner?	eath (Check only one) Home 5 Residence	G [] Other (G)	
ō	Phy ar this aral d	n; To	Impatient Zillervoutpatient Sill DOA 4 Intuising	28d. Describe how in		Y)
Division	Attending r death. sctor: After by the fune	atlo	1 Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No			
N N	Atter	ifice	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Sta	and Number or Rura	I Route Number,
Ö	s afte	Certification;	building, etc. (Specify)	Only of Yours, Siz	210)	
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	cal (29a. Certifier (Check only (Check only Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only (Check on	ce, and due to the cause	(s) and manner as s	tated.
	the H nin 24 the F	Medical	one) and manner stated.			
	James Pos	2			Date signed (Month,	
•			My fedelum 12638) -1	ma, a	+005
			30. Name and address of person who completed pause of death (Item 23a) (Type, Print) Michael Padden Ma 302 Collins Hu	nlock		
			31. Date filed (Month, Day, Year) JAN 0 5 2005 32. Registrar's Signature JAN 0 5 2005	ing .		
	Sta Regist		31. Date filed (Month, Day, Year) JAN 0 5 2005 32. Registrar's Signature JAN 0 5 2005			
			1-00-			

State of Maryland / Department of Health and Mental Hygien 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** d:18 6m ELLERMAN JANUARY 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ARRO If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Virginia 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Ye March 26 7. Age (In yrs. last birthday, **Funeral** Days Hours Min. 1 □ M 254 F 217 46 5158 90 1914 Director Usuel Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show eny Injury or other traumatic event, the Medical Exam her must be notified at Md. Frederick Woodsboro 1 ¥Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11 Rosewood Court 21798 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22€No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 White 1 Yes 2 No 3 ⊠Widowed 4 □ Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation. 16b Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Noah Otis Zirkle Laura Ellen Shutters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Rosewood Court, #104, Woodsboro, Md. Bobby J. Case / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Parklawn Cemetery 1/5/05 Rockville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Muriel H. Barber Funeral Home
P. O. Box 5038, Laytonsville, 21. Signature of Funeral Service Licensee muru 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or ava consequence of): **Physician** MM /Medical Examiner SIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Examiner as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Division of Vital Records, P.O. Box 68760, the attending physicien Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy the funeral director, page 2 should be detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Hunknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 1 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes Medical Certification; To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 🗌 Yes 2 🗌 No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 who completed cause of death (Item 23a) (Type, 30. Name and address of person ANNOPONS ROO MELING O 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar JAN 04

			1 - For State Registrar	State of	Maryland /		artmen <i>rtificat</i>			and M		ene 20	05	01209
	Dhysisi	4	1. Decedent's Name (First, Middle,	Last)							2. Date of Death Month		Year	3. Time of Death
	Physici /Medio		Martha	Parks	Forrest						January			12:30 P M
	Examin		4a. Facility Name (If not institution,	give street and numi	ber)				Location o	of Death		4c. County o	f Death	
			11100 Asbury					Solor					vert	
	Funeral		, , ,	6. Sex 7 1 □ M 2 🛣 F	. Age (In yrs. last	birthday) Yrs.	Months Months	1 Year Days	If Under:	24 Hrs. Min.	Date of Birth (Month, Day,	Year)	Birthp Coun	lace (State or Foreign try)
	Director		179-16-0912 Usual Residence of Decedent		87	115.					May 13,	1917	Penn	sylvania
	land ow		10a. State 10b. County		10c. City, To	own or Lo	cation						1	0d. Inside City Limits
	Mary -f sh	tor	MD Calv	ort		Solon	none							1 ☐ Yes 2 No
	r 288	Director	10e. Street and Number			,0101	10f. Zip	Code			10	g. Citizen of Wi	nat Coun	try?
	h witi	al D	11100 Asbury C	ircle Apt.	# 103			20	0688			United	Sta	tes
	deat	Funeral	11. Marital Status		ent Ever in U.S.	13.	Was Dece			gin? (Spe	cify Yes or No- Rican, etc.)	14. Race	- Americ	an Indian,
9	or Ita	/Fu	1 Never Married 2 Marrie			3	1 ☐ Yes			i, rueito	nican, etc.)	Specify:	White,	
21215-0036	ural',	d by	3 ₩ Widowed 4 □ Divorced	Year or Dat	es: 1946							Specify:	AAIIT	
Ϋ́	"nati	Completed	15. Decedent's (Specify onfy highest		16	(Give	dent's Usua kind of wo	rk done d	lurina most	t of worki	ng 1	6b. Kind of Bus	iness/Ind	dustry
12	withir sne.	dm	Elementary/Secondary (0-12)	College (1-4	for 5+)		DO NOT u	se retired,)			a1	a	
2 2	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28a-f show ant, the Medical Examinat must be notified at		12 17. Father's Name (First, Middle, L	ast)		Cler	CK.		18 Mothe	r's Name	(First, Middle, M	Civil		ice
Maryland	d be antal cad o	To Be	John Bratton	1							Trout	and on Camano	,	
<u>-</u>	shoul nd Me mark	Ĕ	19a. Informant's Name/Relationshi		maana 1 1	9b. Mailin	ng Address	(Street a				City or Town S	tate Zin	Code
S S	lth ar 27 is r trau		Paula J. Will											
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Itams 23a or 28a-f show any injury or other traumatic avant. The Medical Examinat must be notified at once.		20a. Method of Disposition		20b. Place							0c. Location - C		
Baltimore,	Page lent o nt: If ry or		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		a.g. //		ld-Ec		ļ -		-	harlott	о На	11 MD
ä	mit. partm porta / inju		21. Signature of Funeral Service L	censee	H						nsfield			
m	Depa Impo any ir		David A. Gof	f 2016	M0109									and 20650
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	opplication, that									Ī	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	(A)	\			- 1	1.	7	Couch			Onset and Death
	/Medical		resulting in death)	Due to (o	as a consequenc		cai	<u>, </u>	er	- 	1/60 611	6 / \		
	Examiner		Sequentially list conditions,		von GV	4	17.	to	17	12,	sease	_		
	Sit 9d	inei	if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequenc	e of	i	,	1					
	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (o	as a consequence	1 (C	- N	400	v te	121	9			
8760,	be exician buria			540 (0)	as a consequenc	o oi).		11						
687	phys phys s the	dical		d				**						
ŏ	leath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy							23d. Date	of dolino	
$\mathbf{\alpha}$	death atter	clar	in the past 12 months?		h 2 □ Fetal dea nt at time of death		Ectopic pr Other (sp					Monti		Day Year
o.	that the de led by the a detached t	Physician/Me	9 Unknown	9□ Unknow	'n									
<u>ر</u>	res that igned b	by P	Part II. Dther significant condition	s contributing to dea	th but not resulting	j in the ur	ndertying ca	ause give	n in Part I.		23e. Did toba	acco use contrib	ute to th	e cause of death?
Records,	w require been sig should b										1 ☐ Yes	2 □ No 3	☐ Proba	ably 4 Unknown
000	aw re	Completed									24a. Was an		ere autop	sy findings available
_		E O									autopsy perform 1 Yes 2	ed2 de	ath?	pletion of cause of
Vita	ysician: Th	Be C	25. Was case referred to medical examiner?						26. Place	of Death	Check on	•		
<u>></u>	Physic this co	၉	1 Pes 2 No	Hospital: 1 ☐ Inc		Dutpatien		Othe	r: 4 🗆 Nur	rsing Hon	ne 5 Mesiden	ce 6 Other	(Specify)
Ē	ing P	on:	27. Monner eath 1 atural 5 Pending	28a. Date of (Month,	Injury 28b Day Year)	. Time of Injury		8c. Injury Work			8d. Describe how	v injury occurred	i	
<u>S</u>	Attanding Physician: ir death. actor: After this certifice by the funeral director, I	cat	2 Accident investigation investigation and Suicide 6 Could not	t be			М		′es 2□N	-				
Division of	i Diffe	Certification:	4 ☐ Homicide determin	280. Place of	f Injury - At home, , etc. <i>(Specify)</i>	tarm, stre	eet, factory	r, office		2	8f. Location (Stre City or Town,		or Rural	Route Number,
_	To the Hospital or A within 24 hours after To the Funaral Dira completely filled in b		29a. Certifier 1 ☐ Certifying	Physician: To the b	est of my knowled	de desth	Occurred .	at the time	e date and	1 place o	nd due to the as-	ise(s) and man-	er ac et	ated
	24 hos 24 hos a Fun etely	Medical		xaminer: On the bas and manne	is of examination a	and/or inv	estigation,	in my op	inion, deat	h occurre	nd due to the cat ad at the time, dat	te and place, an	d due to	the cause(s)
	To the Hospital within 24 hours a To tha Funaral completely filled	Me	29b. Signature and title of certifier	- 01	()	-/-	290	. License	number		296	d. Date signed (Month, L	Day, Year)
	, ,,,,,		1 the [1111	11/1		17	117	127	CI		January	z 10	. 2005
N			30. Name and address of person w	no completed cause	of death (Item 23a	(Type,	Print)	J_1_	1 70	7		January	, 10	,
الم	10		Raymon Noble,	M.D. 32 C	ox Road	Hunt	ingto	own,	Mary]	land	20639			
	Sta		31. Date filed (Month, Day, Year)	32. Rec	rar's Signature	1.								
	Registr	ar	JAN I	T TOOD	37-00 10-	12	Annak	5 18						

		Please		nt in Black Ir aryland / Dep			-			0101	
		1 - State Registrar		Ce	ertificate of	Death		Reg. No.	000	01210	
Di		1. Decedent's Name (First, Middle, Las	t)				2. Date of De	eath Day	/ Year	3. Time of Death	
		Carlos Lee Fryman					January	14,		5:45 A.	
		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c.	County of Deal	h	
		St. Mary's Nursing	Center		Leonard			S	t. Mary's		
		5. Social Security Number 6. Security Number 11 11 11 11 11 11 11 11 11 11 11 11 11	WM 2DE	e (In yrs. last birthday 82 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of 8i (Month, D. June 17,	ay, Year)	9. Birtl Co Kent	nplace (State or Foreig untry) ucky	
iryland ihow		10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limit	
Ba-f.	cto	Maryland St. Mary's	3	California						1 ☐ Yes 2 🕱 No	
or 2	Dire	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What Co	untry?	
ath w	ra E	23465 Kingston Creek			2061			USA			
rs after de	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 🎖 Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:	No	. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White Specify: Wh		
2 hou	ed	15. Decedent's Ed	ucation	16a. Dec	edent's Usual Occup			16b. K	ind of Business/		
ithin 7:	Completed	(Specify only highest grad Elementary/Secondary (0-12)	de <i>completed)</i> College (1-4or t	i+) life.	DO NOT use retire	during most of work d)	king			,	
To the Hospital or Attanding Physician: The law requires that the death certificate be executed to the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit are completely filled in by the funeral director.		12 17. Father's Name (First, Middle, Last)		Stri	p Miner	19 Mothodo Nom	na (Circa Adiedella		ining		
	Be					18. Mother's Nam					
	7	Herman Fryman 19a. Informant's Name/Relationship (7)	vne Print)	19h Mai	ling Address (Street	and Number or Rui	izabeth W	-		in Code)	
		David Wayne Fryman	<i>ypo, r runy</i>					-			
Hear Hear Sther		20a. Method of Disposition	osition (Name of	ingston Creek Road, California, Maryland 20619 Date 20c. Location - City or Town							
ages ant of tt: If i		1 ☐ Burial 2 🛣 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify			ematory or other pla	Januar	ry 15,	41 -			
nit. P artme ortan Injur		21. Signature/of Funeral Service Licen	# //		tan Cremato 22. Name and Addre				andria, V		
ang de g		The wheel Here	A. S.			70, Leonardi	ttingiey- town, Mar	yland	ner Funer. 20650	al Home, P.A.	
		23a. Part1. Enter the disease or comp	olications that caused	the death. Do not er	nter the mode of dyi	ng, such as cardiac	or respiratory a	arrest,		Approximate	
Dhysician		Immediate Cause (Final	one cause on each li		uluse					Interval Between Onset and Death	
		disease or condition resulting in death)	a	a consequence of):	41410						
Examiner				Sep 815							
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):							
cuted od ransil	Examiner	that initiated events	c. C	AD							
an ar	EX	resulting in death) Last Due to (or as a consequence of):									
ate be nysici	cal		d								
certifica nding pt use as ti	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date of deli	verv	
death be atte	sicia	in the past 12 months? 1 \[\text{Live birth} \ 2 \] \ \text{Fetal death} \ 3 \] \ \text{Ectopic pregnancy} \] 1 \[\text{Yes} \ 2 \] \ \text{No} \] 9 \[\text{Ukhown} \] 9 \[\text{Ukhown} \]							Month Day Year		
at the death certifical by the attending phy leterated for use as the	hy	9 □ Unknown									
es the igned	by F	Part II. Other significant conditions co	ontributing to death b	ut not resulting in the	underlying cause gi	ven in Part I.				the cause of death?	
To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death and Manual Hygin and San or 288-1 show of completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of the completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of the complete of th	ted						10	Yes 2	□ No 3 □ Pro	obably 4 Unknow	
law r as be	ompleted						24a. Was	s an	24b. Were au	topsy findings available	
The ate h	Con							ormed? 2 X No	death?		
cian: ertific ector,	Be (25. Was case reterred to medical examiner?				26. Place of Dear	th (Check only				
hysic his ce	10	1 ☐ Yes 2 No		ent 2 ER/Outpatie	ent 3□ DOA Ot	ner: 4 Nursing Ho	ome 5 Res	idence	6 □Other (Spec	cify)	
ng Pi	on:								y occurred		
the fu	cati	2 Accident investigation]Yes 2□No					
al or Att	Sertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In	ury - At home, farm, s c. (Specify)	treet, factory, office			(Street an own, State		ral Route Number,	
Hospitu 24 hours Funara etely fille	edical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best niner: On the basis o and manner st	of my knowledge, dea f examination and/or i	ath occurred at the finnestigation, in my	me, date and place, opinion, death occur	, and due to the rred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)	
o the vithin o the	₩ W	29b. Signature and title of certifier			29c. Licen			29d. Dat	te signed (Month	n, Day, Year)	
		> 7081	rah		D	47061	6	1.	14.0	5	

State Registrar DHMH 17 Rev 1/2001

D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. A. D. Shah, Medical Arts Building, Leonardtown, Maryland 20650

31. Date filed (Month, Day, Year)

32. Register's Signature

33. Register's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Abraham Abo FRAMM lanuary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1X M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Oct. 19,1926 Birthplace (State or Foreign Country) **Funeral** Days Hours 78 Yrs. Director 219 14 9974 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28a-f shov traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 236 South Mulberry Street 21740 Items 23e USA Completed by Funeral should be filed within 72 hours after death and Mental Hyglene. 12. Was Decedent Ever in U.S. Armed Forces? 1 透Yes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced white "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hyglene. Coilege (1-4or 5+) Elementary/Secondary (0-12) driver bread company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ruben Framm Ida Halprin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is m any injury or other traum 90028. Debbie Vance - daughter 8937 Light Street, Williamsport, Md. 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Cedar Lawn Mem. Park 1/7/05 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 East Wilson Blvd., Hagerstown, Md. 21740 236 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-tran that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 ☐ No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 1 Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗍 Suicide

Division of Vital Records,

or Attending Physiclan: The law requires that the death certificate be executed Certification: To after death 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 'Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. (Check only one) within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 01,05,205 30. Name and address of person who complet d cause of death (Item 23a) (Type, Print) Hagerstown 12821 Hill Hoerive Oak 19ba 511-12+1 32. Registrar's Signature State 2005 Registrar Speck)

		_ FOI	epartment of Health and Certificate of Death	Mental Hygie				
		Decedent's Name (First, Middle, Last)	2. Date of Death Month	3. Time of Death				
Physici /Medi Examir	cal	Vivian Lucille Gibson 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	January	3 2005 1510 P M 4c. County of Death			
LXuiiii		Clinton Nursing & Rehab. Center	Clinton	ı	Prince George's			
Funeral		5. Social Security Number 6. Sex 1 ☐ M 2 ☒ F 7. Age (In yrs. last birthe	Months Days Hours Min.	(Month, Day, Yo				
Director		356-05-4353 92 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of		Sep. 11,	1912 Kentucky 10d. Inside City Limits			
death with the Maryland ms 23a or 28a-f show	ector	Maryland Prince George's	District Heights		1∰Yes 2 No			
th with the 23a or 2	Funeral Director	10e. Street and Number 2003 Wintergreen Ave.	10f. Zip Code 20747	10g.	Citizen of What Country? United States			
ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Itams 23e or 28e-f show or other traumatic event. It is Marical Examinating as the notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☐ No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black			
be filed within 72 hours after ital Hygiene. do other then "neturel", or Ital event, the Madical Experime	Completed	15. Decedent's Education (Specify only highest grade completed) ((Specify only highest grade completed) ((Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of wo fe. DO NOT use retired)	rking 16i	b. Kind of Business/Industry			
ed wit /gien lar th	Con	12th	Domestic		Private			
nd 2 should be fill Ith and Mental Hy 27 is markad oth r traumatic evani	To Be	17. Father's Name (First, Middle, Last) Herman Richard Wilson	18. Mother's Nai	ne (First, Middle, Mai Alberta				
and h		19a. Informant's Name/Relationship (Type, Print) 19b. M	Mailing Address (Street and Number or Re	ıral Route Number, C	ity or Town, State, Zip Code)			
and sealth m 27					ct Heights, MD 20747			
Pages 1 nent of H int: If ita		1 🛣 Burial 2 □ Cremation 3 □ Removal from State cemetery,	disposition (Name of crematory or other place)		c. Location - City or Town, State			
it Partitude intentional injury		' 4 □ Donation 5 □ Other (Specify) Zacha 21. Signature of Funeral Service Lighnsee	ary Taylor Cem. 1/1 22. Name and Address of Facility	/10/2005 Louisville, KY Stewart Funeral Home				
permi Depa Impo any is		Jahr J. Steren TT.	4001 Benning Rd.					
		23a. Park Enter the disease, or complications that callsed the death. Do no shick or heart failure. List only one cause on each line. Immediate Lause (Final disease of condition	t enter the mode of dying, such as cardia	or respiratory arrest				
Physician /Medical Examiner	ı	disease of condition resulting in death) a. Due to (or as a consequence of)	sch Conce	neer				
bed ,	Examiner	Sequentially list conditions, 1 any leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
eath certificate be executed attending physician and for use as the burial-transit	cal Exar							
certificate rding phys		d.						
00	hysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year			
w requires that the been signed by th should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the		co use contribute to the cause of death? 2 No 3 Probably 4 Unknown				
sician: The law req certificate has beer irector, page 2 shou	ompleted		24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?				
ifficate or, pa	ပိ	25. Was case referred to medical	26 Place of De	1 ☐ Yes 2 ☑ ath (Check only one)	No 1 ☐ Yes 2 ☐ No			
> 00 0	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	Othor		e 6 Other (Specify)			
fing After fune		27. Manner of Death 1 ★Natural 5 □ Pending 2 □ Accident		28d. Describe how injury occurred				
	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)			
To the Hospital or within 24 hours afte To tha Funaral Discompletely filled in	edical C	29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, (Check only one) 1 **Medical Examiner: On the basis of examination and/one) and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occurred.	e, and due to the caus urred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)			
To the within 2 To tha complet	Med	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)			
F S F O) acomor som	P00370	66 01	-05-2005			
3		30. Name and address of person who completed cause of death (Item 23a) (To Complete Cause of Cause Cau	ype, Print) 6/88 0	con Hil	-05-2005 1 Rd #701 D 20745			
St	ate	31. Date filed (Month, Day, Year) 2. Registrar's Signature.	OXOIV	ITII, M	1) COTYS			
Regist	trar	JAN 0 7 2005 See &	ach!					

			For State Registrar	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 5 0 2							01213			
			Decedent's Name (First, Middle,	Last)							2. Date of Dea	th	Vans	3. Time of Death
	Physicia		Willie	Jam	es		Gree	n	Sr.		Month 1	Day 3	Yeer OS	11:30 A M
	/Medic Examin		4a. Facility Name (If not institution,	give street and number	r)		4b. City, T	Fown, or	Location of	f Death		4c. C	ounty of Deat	h
	LAdilliii	ÇI	3706 65th Avenu	e			Lar	ndov	er			Pı	cince (George's
	Funeral			. Sex 7. /	Age (In yrs. i	ast birthday)	If Under	1 Year	If Under 2		8. Date of Birth (Month, Day			nplace (State or Foreign untry)
	Director		579-50-0100	1 ∑ M 2□F	66	Yrs.	Months	Days	Hours	Min.	1-14-3	8	Sou	th Carolina
7			Usuel Residence of Decedent											
-	portificion of the standard of the control of the many and permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. The Medical Fram her must be notified at the page.	,	10a. State 10b. County		10c. City	, Town or Lo								10d. Inside City Limits
1	a-f.s	cto	MD P.G.			Lando	over							1 XYes 2 □ No
4	or 28	Director	10e. Street and Number	_			10f. Zip Code 10g. Citizen of V						on of What Co U.S	-
4	23a	a	3706 65th Avenu									144		
1	tems	Funeral	11. Marital Status	Armed Force	Armed Forces? If		Was Deced If Yes, spec	ent of Hi	spanic Orig n, Mexican	, Puerto	cify Yes or No- Rican, etc.)	14	14. Race - American Indian, Black, White, etc.	
9	or l	by F	1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give			1 ☐ Yes 2 X No Specify:			Specify: B			ıck	
3	al E.		15. Decedent's			16a Dece	16a. Decedent's Usual Occupation					16b. Kind of Business/Industry		
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yland	d be ental ked c	To B	James Mosley						Kat	herl	ee Gree	n		
	nd M mar	-	19a. Informant's Name/Relationshi	(Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	r or Rura	l Route Numbe	r, City or 1	Town, State, 2	(ip Code)
M	Ith all		Margaret Green			3706	65th	Ave	nue La	ando	ver, MD	2078	34	
ຄົ .	Hea Hea Item othe		20a. Method of Disposition		20b. P	face of Dispo	sition (Nam	ne of	e)	С	ate	20c. Loca	ation - City or	Town, State
₽,	y or		1 X Burial 2 ☐ Cremation 3 1 4 ☐ Donation 5 ☐ Other (Specific Action 1)		te	. Line	,			1-8-	05	Bren	itwood,	MD
aitimor	ortar injur		21. Signature of Funeral Service Li		000		2. Name and	d Addres	s of Facility	у	_		_	
Ď	Departing once		Reginald	Si Cal	RIO!	ν					Funera			
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B B	nutica ng ph as th	Ü	IF FEMALE.											
Š R	in cei	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1 ☐ Live birth			∃Ectopic pre	egnancy				23	d. Date of del	,
	death ne atter ed for u	sicia	in the past 12 months? 1 □ Yes 2 □ No		5 Other (specify)				Month Day Yea		Day Year			
י כ	at the by th	Physician/M	9 Unknown	9□ Unknowr							T			
ຼ ທົ	requires that the death certificate be executed been signed by the attending physicien and hould be detached for use as the burial-transit	by F	Part fl. Other significant condition	s contributing to death	n but not res	ulting in the u	inderlying ca	ause give	en in Part I.					the cause of death?
ecords	w require been sig should b									es 2 🗆	2 No 3 Probably 4 Unknown			
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Vital K	Physician: The physician of this certificate ral director, pag	Be C	25. Was case referred to medical examiner?						26. Piace	of Death	(Check only o			
>	Physician: r this certific ral director,	Tof	1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpa	atient 2	ER/Outpatie	nt 3 DO	A Othe	∍r: 4 🗆 Nu	rsing Ho	me 5 🔀 Resid	ence 6	□Other (Spe	cify)
	ding Pt h. After th funeral		27. Manner of Death 1 XNaturaf 5 ☐ Pending	28a. Date of I (Month,	njury <i>Day Year)</i>	28b. Time o	of 2	8c. Injury Work	at </td <td></td> <td>28d. Describe h</td> <td>ow injury</td> <td>occurred</td> <td></td>		28d. Describe h	ow injury	occurred	
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<u>≅</u>	or Attending after death. Director: After in by the fune	ţij	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 280. Flace of	Injury - At he etc. (Specif	ome, farm, st	reet, factory	, office			28f. Location (S City or Tow		Number or Ru	iral Route Number,
	itel c irs aff rel Di led ir	Certification:												
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	the hin 2: the I	Medi	one)	and manner	stated.		200	License	number			29d Date	signed (Mont	h Nav Yearl
	With To 1		29b. Signature and utter of certifier	nature and little of certifier 29c. License number 29c. License number							7-0			
1	(10)		,	//		40		0	71/			/	10	<i>,</i>
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			Chipra Venka 31. Date filed (Month, Day, Year)	traman 6	201 (Green	elt	Rd,	Col	1 eg	e Pk,	$_{\mathrm{MD}}$ 2	0740	
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Documents Statem First, Morein, Last March Y Viola Gladhill Seath Statem New First Morein or season of Share Seath Statem Number Prederick Seath Statem Number Sea			1	For State Registrar	State of Marylan	d / Departi			-	21115	01214
## COLVESTOR DESIGNATION Plants are considerable and the country of part of part of the country of part of pa	Phy	ysicia	_	1. Decedent's Name (First, Middle, Last)						Day 2005	3. Time of Death 11:45 P M
Supplemental procession True Tr			_	la. Facility Name (If not institution, give s		Death	4	c County of Death			
100 100				219-66-3637		M		Min. 8. Da	te of Birth onth, Day, Yea ne I,	1917 9. Birth	place (State or Foreign intry) MD
19. Mother's Name (First, Middle, Last) 19. Mother's Name (First, Middle, Maison Sumane) 19. Mother's	Maryland	fled at		10a. State 10b. County							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
19. Mother's Name (First, Middle, Last) 19. Mother's Name (First, Middle, Maison Sumane) 19. Mother's	h with the	at be not	ai Direc		Church Rd.	1			10g. (
19. Mother's Name (First, Middle, Last) 19. Mother's Name (First, Middle, Maison Sumane) 19. Mother's	urs after deet al', or Itame	Examiner mu	by Funer	1 Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1		in? (Specify Yo Puerto Rican,	es or No- etc.)	Black, White	, etc.
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Major Sumane) 19. Mother's Name (First, Middle, Major Sumane) 19	within 72 ho	a Medical	mpieted	(Specify only highest grade Elementary/Secondary (0-12)	e completed)	(Give kind	of work done during most of NOT use retired)	of working	16b.		
Physician Medical Examiner Ph	ld be filed viental Hygie	Ic event, it	Be	17. Father's Name (First, Middle, Last)	artsock		18. Mother Ber	tha Ma	ae Kel	en Sumame) ller	
Physician Medical Examiner 2 2 2 2 2 2 2 2 2	nd 2 shou aith and M 27 is mar	ır traumat		19a. Informant's Name/Relationship (Ty Kay Gladhill (1	_{rpe, Print)} Daughter)	19b. Mailing A 3709 E	ddress (Street and Number Brethren Ch	or Rural Rout urch	e Number, City Rd • • • • • • • • • • • • • • • • • • •	y or Town, State, Zi Myersvil	le, MD
Physician Medical Examiner 2 2 2 2 2 2 2 2 2	Peges 1 annent of Hei	ury or othe		Burial 2 ☐ Cremation 3 ☐ F	temoval from State H	Place of Disposition in the Disp	n (Name of ny or other place) Cemetery 1			•	
Physician Medical Examiner Physician Medical Examiner	permit. Departr Import	any inj		X A DO	with	31	E. Main St	., Mi	ddletc	al Home	21769
Due to (or as a consequence of): The control of	/Medi	ical		Immediate Cause (Final disease or condition				-			Approximate Interval Between Onset and Death
The stand of the	ate be executed hysician and	e pr	cal Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	o						
1 Yes 2 No 3 Probable	the death certific	ched for use as	ysician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	il death 3 □Ect					very Day Year
25. Was case referred to medical examiner?	quires that	uld be deta	d by Ph	Part II. Other significant conditions co	ntributing to death but not res	ulting in the unde	rtying cause given in Part I.	2:			
25. Was case referred to medical examiner?	The law rec	page 2 shou	omplete						autopsy	prior to c	opsy findings available ompletion of cause of
Second S	ician:	ector,	Be	examiner?	Hospital:		Other 1				
Second Property Second Pro	Phys.	ō	. To	1 Yes 2 No Residence 6 Other (Specify)							ify)
3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, lactory, office 28f. Location (Street and Number or Rural Finding Political Finding Polit	th.	e fune	ation		(Month, Day Year)			lo			
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and did address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	tal or Atters after dea	ed in by th	Certifica	determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street,	lactory, office				ral Route Number,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, De 1) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	e Hospi 24 hou.	etely fill	dical	(Check only 2 Medical Exami	ner: On the basis of examina						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To the Within	сошр		29b. Signature and title of certifier	.1	. 0	29c. License number	91			
	7			30. Name and address of person who ca	ompleted cause of death (Iter	n 23a) (Type, Prir	D 283	- 1		7-6-03	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		Sta	te	SAJJAO/HZ	-12,1MD -8,	OI TO	ILL HOUSE	HVZ	E, 1	rectified	MD 2170

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene #10e, #20b, per Funeral Homertificate of Death Reg. No. 01/07/05 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** MADELINE AMELIA 2,2005 GAIGLER January 2210 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner <u> Atlantic General Hospital</u> Berlin
If Under 1 Year If Under 24 Hrs. Worcester Birthplece (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 M 2 F Yrs. Director 212=22=3906 MD 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Examiner must be notified at 18 Yes 2 No Funeral Director Md. Worcester Ocean Pines 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 12Greenwood Lane 21811 <u>USA</u> 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 3 ☑ No Specify. ģ Specify: 3 Widowed 4 Divorced White Completed The Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hygir Important: If item 27 is marked other any injury or other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Nolan Hughes Lillian M. Ackerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Greenwood J
1Se 12 Dreamwood
20b. Place of Disposition (Name of cemetery, crematory or other place) Ocean Pines, Md., 2
Date 20c. Location - City or Town, State Kenneth W. Gaigler Spouse 21811 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, Md. 21. Signature of Funeral Service License 22. Name and Address of Facility Ullrich Funeral Home Berlin, 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician metestatic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 4-6-1923 Due to (or as a consequence of) -2-03 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 Tyes 2 HNo 3 Probably 4 TUnknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 🗌 Yes 2 9 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Impatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29b. Signature and title of certifier 29c. License number physicia 30. Name and address of person who completed cause of d inth (Item 23a) (Type, Print) 31. Date filed (Month, Dav. Year)

DHMH 17 Rev 1/2001

State

Registrar

JAN 0 5 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year Physician 2005 12:10 AM Griffin January Elizabeth Mary /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Montgomery Manor Care of Potomac If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Funeral Days Months Hours 1 □ M 28 F Yrs 89 Director July 7, 1915 <u>066-16-4</u>031 New York Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours after death with the Maryland nent of Health end Mantal Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits I Hygiene. other than "natural", or items 23s or 28s-f show rent, the Medical Examiner must be notified at 1 Nes 2 No DE Directo Sussex Rehoboth Beach 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 409 Bayard Avenue 19971 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. If Yes, Give Year or Dates: Specify: White ģ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Otho Lee Monroe, M.D. Ann Lyon Marshall 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dapartment of Health of Important: If item 27 is any Injury or other tra Patrick Joseph Griffin III/Son 14101 Berryville Road Darnestown, Md. 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State Jan.5, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2005 Rockville, Maryland 21. Signature of Fur al Service 22. Name and Address of Facility DeVol Funeral Home Gaithersburg, MD 20877 10 E. Deer Park Dr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Advanced Dementia Examiner Due to (or as a consequence of): Physiclan/Medical Examine Vascular Disease or Attending Physician: The law requires that the death certificate be axecuted attanding physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Atherosclerosis Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Hypertension þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed s certificete hes b director, pege 2 s 1 Ves 2 2No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 X No this After this funeral of Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / 6 Could not be 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours eft.

To the Funeral Dir

complataly filled in 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the. 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of certifier lo D31319 January 3,2005 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 8218 Wisconsin Ave. #305 Bethesda, MD 20814 Loreto S. Albiol, M.D. 31. Date filed (Month, Day, Year) 32. Begistrar's Signature

State

Registrar

JAN 04 2005

115-20-45/3 Hill, there

			1 - For State Registrar	State of Ma	iryiand		tificate c		i Mentai Hy	giene Reg. No 20	05	01217
	Physici /Medio		1. Decedent's Name (First, Middle, Las ANNA M.	. 1					2. Date of De Month	Day	Year 05	3. Time of Death 6:45 4. M
	Examir		4a. Facility Name (If not institution, give	· Mada	CON	184	4b. City, Town	n, or Location of De 143644/		4c. County	of Death	ю
	Funeral Director		215-20-4513	7. Age ☐ M 2X F 76		est birthday) Yrs.	If Under 1 Ye Months Day			th ay, Year)	9. Birthp Cour Md •	place (State or Foreign ntry)
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation		<u> </u>		1	0d. Inside City Limits
	death with the Maryland ims 23a or 28a-f show	tor	Md. Wicomic	20	Fru	itland						XX Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Cod	8		10g. Citizen of	What Cour	itry?
	sath w	eral	115 N. Brown St.	12. Was Decedent E	Luce in 11 C	12.1		21826	(Casaita Van an Na	US.	A e - Americ	on India-
250	after or Ita	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Yes, specify C	of Hispanic Origin? Juban, Mexican, Pue No <i>Specify:</i>	arto Rican, etc.)	Bla	ck, White,	etc.
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V	be filed within ntal Hygiene. nd other then '		3 17. Father's Name (First, Middle, Last)			Homem	aker	18. Mother's N	ame (First, Middle	Ho: , Maiden Suman		
מום	should be nd Mental markad o matic ave	To Be	William Alexande	r				Geneva	a Malcom	Alexand	er	
	2 should and Men is marks sumstic		19a. Informant's Name/Relationship (7	ype, Print)			•	eet and Number or	Rural Route Numb	er, City or Town,	State, Zip	Code)
ກ໌ ຂ	1 and 1 Health am 27 ther tr		A. Lee Alexander 20a. Method of Disposition	, Son	20b Pla			dge Rd.	Delmar,	Md. 218		Ctato
	ages ant of I tr. If its y or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				sition (Name of natory or other p	o ^{lace)} :lmarva 1-		Delmar		
Dallimor	permit. Pages 1 and Department of Heatl Important: If itam 2 any injury or other Once.		21. Signature of Funeral Service Licen		02.	22	Name and Ad Short F	dress of Facility 'uneral Ho	ome			
			23a. Part 1. Enter the disease, or comp	lications that caused	the death.			rove St. tying, such as cardi			40	Approximate
,	Physician /Medical		shock, or fleart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Sever	12 CI	supeo	ive t	lean-	Pelé I W	, Q.		Interval Between Onset and Death
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	D =	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	bue to (or as a		erice of).	. 11	nemic	LBAAM.	<i>J</i> .		
	and and I-trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	CODSEGN	_	C. 11/11		JC GOOVI			
0/00,	tificate be executed g physician and as the burial-transit	edical E		d.								
00	ntificating physes as the		IF FEMALE:									
O. DOX	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth : 4 □ Pregnant at t 9 □ Unknown	2 🗌 Fetal	death 3	Ectopic pregna Other (specify)			1	te of delive nth	ry Day Year
Ľ,	ires that t signed by d be detac	by	Part II. Other significant conditions co	ntributing to death bu	it not resul	lting in the un	derlying cause	given in Part I.				e cause of death?
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	cian: ertifica ector, p	Bec	25. Was case referred to medical examiner?						eath (Check only o			
5	Physic this c	P.	1 Yes 2 No	Hospital: 1 ☐ Inpatier 28a. Date of Injun		R/Outpatient	3L DOA		Home 5 Resid)
5	ding th. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	28b. Time of Injury	V	njury at Vork? □ Yes 2 □ No	280. Describe	how injury occur	90	
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At hor . (Specify)	ne, farm, stre			28f. Location (S City or Tox	Street and Numb wn, State)	er or Rura	Route Number,
	Hospite 24 hours Funaral etely filled	Medical C	29a. Certifier (Check only one) 1 Medical Exam	rsician: To the best of iner: On the basis of and manner stat	examinati	vledge, death on and/or inv	occurred at the estigation, in m	a time, date and pla y opinion, death oc	ce, and due to the curred at the time,	cause(s) and ma date and place,	inner as st and due to	ated. the cause(s)
	To the within To the comple	Me					29c. Lice	ense number	0	29d. Date signe	d (Month, I	Day, Year)
	3		1 Month					20031	О,	11.57	05	
	9		29b. Signatule and title of certifler 30. Name and address of person who come the second sec	ompleted cause of de	ath (Item	23a) (Type, F	nint) (S)	tors i) sine.	SALISI	3 mg	, m.D
	Sta Registr	te	31. Date filed (Month, Day, Year) JAN 0 7 2	32. Restra	r's Signati	Jre A	Cart.					

			For State Registrar	State of M	arylan		artment rtificate			and M	F	Reg. No.	005	01218
	Discortat		1. Decedent's Name (First, Middle	, Last)							Date of Dea Month	ath Day	Year	3. Time of Death
	Physici: /Medic	_	Arlene	Gause			Ha	mlin	1		anuary	9,	2005	
2	Examin		4a. Facility Name (If not institution	, give street and number	r)		4b. City,	Town, or	Location o	of Death		4c. C	ounty of Deat	th
			18719 Preston F					rsto		0411-0			lashing	
	Funeral		5. Social Security Number	6. Sex 7. A 1 ☐ M 2 ဩ F	-	last birthday) Yrs.	If Under Months	Days	Hours 1	Min.	8. Date of Birt (Month, Da	y, Year)	Co	thplace (State or Foreign ountry)
	Director		190-28-9244 Usual Residence of Decedent	-X	77	113.					Sept.	21,19	2/ Pen	nsylvania
	and and		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Maryl 1 sho	ō	MD Wash	ington	на	gersto	T-713							1 ☐ Yes 2 📉 No
	28a	rec	10e. Street and Number	Ingcon	IIG	gersto	10f. Zip	Code		<u> </u>		10g. Citize	en of What Co	ountry?
	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f show the Medical Examiner must be mulliand at	by Funeral Director	18719 Preston	Road				2174	2			U.	S.A.	
	death	Jera	11. Marital Status	12. Was Deceder		S. 13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	. 14	Race - Ame	
9	after or Ite	Ē	1 ☐ Never Married 2 🛣 Marr	Armed Forces ied 1 ☐ Yes 2 ☐ If Yes, Give		i	irres, spec 1 □ Yes 2		Specify:		nican, etc./			
21215-0036	raf',	ğ	3 Widowed 4 Divorced	Year or Dates	:		103 2		opacity.				Specify: Wh:	
5-0	72 h	Completed	15. Deceden (Specify only higher			(Give	dent's Usua kind of wor	k done d	uring most	t of workir	ng	16b. Kind	of Business	/Industry
21	hen hen	m Id	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Teach	DO NOT us	e retirea,	,			Edu	cation	
	led v tygie her t		17. Father's Name (First, Middle,	(act)		reacin	- L		18 Mothe	r's Name	(First, Middle,			
and	be fi	Be	Harry Glen Ga							na T		741410011 0	umamo,	
3	should be filed within and Mental Hygiene. marked other than " umatic event, the Mac	2	19a. Informant's Name/Relations			10h Maili	an Address	(Street a			Route Numbe	er City or	Town State	Zin Code)
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or Items 23a or 28a-f show apprintly or other traumatic event, the Medical Examiner must be nutilised at ance.	1	Robert L. Haml:			1	•				gerstow			
	1 and Healt em 2 ther		20a. Method of Disposition	,	20b. F	Place of Dispo					ate		ation - City or	
٥	nt of nr or		1 ☐ Burial 2 X Cremation		.6					1/11	/2005	C 2 4-1	1	MD
Baltimore,	it. P.		' 4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		SIII.						/2005 st Have			
Ba	Depa Impo any i		SM. II (ve., Ha			
		1	23a. Part1. Enter the disease, or shock, or heart failure. List	completions that caus	ed the deat				-					Approximate
	Physician /Medical		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Due to (or a	SHA	R C	hou	c O	Retur	ctul	long	die	lerl	Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	is a conseq	uence of):								
,092	eath certificate be executed attending physician and for use as the burial-transit	icai Exar	that initiated events resulting in death) Last	CDue to (or a	is a consec	uence of):								
89	tifica ng ph as th													
.O. Box	law requires that the death certifics as been signed by the attending ph 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	death 3	□Ectopic pro □ Other (sp					23	d. Date of de Month	livery Day Year
<u>α</u>	w requires that been signed b should be dete	ρχ	Part II. Other significant conditi	ons contributing to death	but not res	ulting in the u	nderlying c	ause give	en in Part I			obacco us	-	o the cause of death?
Records,	0 = 0	Completed					·						prior to death?	utopsy findings available completion of cause of
ita	ician: Th certificate rector, pag	Bec	25. Was case referred to medica						26. Place	of Death	(Check only c	ne)		
of Vital	Physician: this certificanal director,	10	examiner? 1 Yes 2 46	Hospital: 1 ☐ Inpa	itient 2	ER/Outpatie	nt 3 DC	Othe	9r: 4 □ Nu	ırsing Hor	ne 5 🔀 Resid	dence 6	□Other (Spe	ecity)
ion o	fing After fune		27. Manner death 1 datural 5 Pending investi	gation	njury Day Year)	28b. Time o Injury	f 2	8c. Injury Work 1 🗆 `	rat k? Yes 2□	No	8d. Describe l			
Division	tal or Atters as after de al Directo	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 288. Place of	Injury - At h etc. (Speci		reet, factory	r, office		2	28f. Location (3 City or Tou	Street and vn, State)	Number or R	ural Route Number,
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	edical		ng Physician: To the be Examiner: On the basis and manner	of examina		vestigation	, in my op	pinion, dea		ed at the time,	date and p	place, and du	e to the cause(s)
	To t To t com	Ž	29b. Signature and title of certifie				290	License	number		7	29d. Date	signed (Moni	th, Day, Year)
•			SIMUEL C	UM, MI)				56K	15/5			1110.	10, 2	06.7
			30. Name and address of person	who completed cause o	f death (Ite	n 23a) (Type.	Print)			\	C'	1 11	,	stown mo
<u>3</u>	H-2		Jamuel Ch	$\Delta a_1, m$	D.	324	Eas!	+ No	stic	tan	1 Stree	4.4	agers	dim nemoti
	Sta Regist		31. Date filed (Month Day, Year)	1 2005 32. Bogi	strar's Sign	ature	serke	,					-	

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	for State		State of Ma		partment of He			/11115	01210
	Registrar	A STATE OF THE STA		CE	ertificate of De	eatri	2. Date of Death	g. No.! U U U	3. Time of Death
Physician		Name (First, Middle, Last,					Month	Day Year	
/Medical	наге	1 Hubbard		нагрег	4b. City, Town, or Lo	ocation of Death	12	2005 4c. County of Death	11:59p
Examiner		ne (If not institution, give	street and trumber)		Easton	ocation of Death		Talbot	,
Surgeral	Willia 5. Social Secur	m Hill Mar	nor 7. Age	e (In yrs. last birthda)	() If Under 1 Year I	f Under 24 Hrs.	8. Date of Birth		nplace (State or Foreign
Funeral Director	212-0	3-4257]м 21ДТ	91 Yrs.	Months Days	Hours Min.	(Month, Day, 1		sboro, MD
P .		ce of Decedent		10a City Tour out	and in		0-22-17	75 GOIG	10d. Inside City Limits
arylar show det	10a. State	Talbot		10c. City, Town or I Easton	Location				Yes 2 No
8a-f				Euscon	104 7in Code		10	g. Citizen of What Co	
II 2 12 15-0030 Ifiled within 72 hours after death with the Maryland Hygiene. Hygiene. When then "natural", or items 23a or 28a-f show ont. The Medical Examination until be notified at a Commission of European Director	10e. Street and	utchmans]	ane		10f. Zip Code 21601			USA	ondy:
eath is 23	11. Marital Sta		12. Was Decedent 8	Ever in U.S. 13	. Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spe		14. Race - Amer	rican Indian,
ter d	1 Never	Married 2 Married	Armed Forces?	No			Rican, etc.)	Black, White	
hours a tural; o	3 ∰ Widow	ed 4 Divorced	1 □ Yes 2 □ N If Yes, Give Year or Dates:		1□Yes X□No	Specify:		Specify: Wh	ice
Z I Z I D-U		15. Decedent's Edu Specify only highest grad	ication le completed)	16a. Dec	edent's Usual Occupation re kind of work done dur DO NOT use retired)	on ring most of worki	ing 1	6b. Kind of Business/l	ndustry
ithin 19.	Etementary/	Secondary (0-12)	College (1-4or 5	1	on of use retired) Terly Pres			rinting	
ild Z IZI		ars ame (First, Middle, Last)		wav			(First, Middle, M.		
Viand vuld be fill Mental Hy arked oth attic even	Ď			3				alour samamo,	
Alarylan 2 should be and Mental is marked craumatic ev		ew Jackson t's Name/Relationship (7)			iling Address (Street and	Anna P		City or Town, State, Z	(ip Code)
A 40 50 50		yn Stewari			00 Rays F			90-71 Vg (15	.Md.21663
re, IM s 1 and 2 f Health item 27 other tra					position (Name of ematory or other place)			0c. Location - City or	
Pages ent of nt: if if	1 Buria	f Disposition (dal) 1 2 Cremation 3 1 tion 5 0ther (Specify)	demoval from State	1	Hill Ceme	eterv 1	-8-2005	Easton.	Μđ
1 1 5 5 5		of Funeral Service Licens		1	22. Name and Address	of Facility			
Depa Depa Impo any is	1 /2	Quel	1 Hen		. Carroll				
	23a. Part1. E	nter the disease, or comp r heart failure. List only of	lications that caused	the death. Do not	nter me mon diving	such as car fine	Michael	s,Ma 216	interval between
Physician	tmmediate Ca	use (Final	Mat	a state	Circu	ma	of Kighil	hune	Onset and Death
/Medical	resulting in de	eath)	a. Due to (or as	a consequence of):	0,-		100	70017	- Syvin neg
Examiner	Sequentially	int conditions	b				V.		
D :=	if any leading						10		
ans ans	cause. Enter	to immediate Underlying	Due to (or as	a consequence of):			10		
- tr 8	cause. Enter Cause (Disea that initiated e	ist conditions, to immediate Underlying se or injury vents ath) Last	c				30		
be exectician and cital-tra	resulting in de	Vents	c	a consequence of):			30		
sicia bur	resulting in de	Vents	c				300		
sicia bur	resulting in de	vents aath) Last	C	a consequence of):				23d. Date of deli	ivery
sicia bur	resulting in de	redent pregnant	c	a consequence of): of pregnancy 2 ☐ Fetal death	3□Ectopic pregnancy 5□ Other (specify)			23d. Date of deli Month	ivery Day Year
death certificate be e attending physicia di for use as the bur	resulting in de	edent pregnant st 12 months?	Due to (or as d	a consequence of): of pregnancy 2 ☐ Fetal death				Month	Day Year
P.O. BOX 68/61 hat the death certificate be so by the attending physicial detached for use as the bur	IF FEMALE: 23b. Was decin the pa	edent pregnant st 12 months?	Due to (or as d	a consequence of): of pregnancy 2 Fetal death time of death	Other (specify)	rin Part I.		Month acco use contribute to	Day Year the cause of death?
P.O. BOX 68/61 hat the death certificate be so by the attending physicial detached for use as the bur	IF FEMALE: 23b. Was dec in the pa 1 Unk Part II. Other:	redent pregnant st 12 months? 2 No	Due to (or as d	a consequence of): of pregnancy 2 Fetal death time of death	Other (specify)	in Part I.	23e. Did tob:	Month acco use contribute to	Day Year
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			State of Maryland / Dep 1 - State Registrar Ce	artment of He			epe 0 0 5	01220
	Physici	an	Decedent's Name (First, Middle, Last)		2	. Date of Death Month	n Day Year	3. Time of Death
	/Medic	al	BESSIE LEE CARICO HANCOCK	45 C'51 Town and		JANUARY	4 2005	2:45PM M
	Examin	er	4a. Facility Name (If not institution, give street and number) WILLIAM HILL MANOR	4b. City, Town, or L			4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. 8	. Date of Birth	7ALI 9. Bi	thplace (State or Foreign
	Director		212-07-6730 1 M 2 K F 95 Yrs.	Months Days	Hours Min.	PR 14	1909 V	RGINIA
	pu k		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L.	ocation				10d Jacida City Limita
	Aaryla f sho	or	MD TALBOT EASTO					10d. Inside City Limits Yes 2 □ No
	the 128a-	rect	10e. Street and Number	10f. Zip Code		10	g. Citizen of What C	21
	h with	al Di	501 DUTCHMAN'S LANE	216	501		US	
	ems a	ner		Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Specif	fy Yes or No-	14. Race - Am Black, Whi	erican Indian,
21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	d by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		Specify:	, σ.σ.,	Specify: WH	
5	"natu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupati kind of work done du	ion Iring most of working	1	6b. Kind of Business	/Industry
12	within ane. than than	duic	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) ACHER			ET EMENT	A DV. TDUG (MT o
	filed Hygi other	e Cc	17. Father's Name (First, Middle, Last)		18. Mother's Name (F	First, Middle, Ma		CARY EDUCATIO
Maryland	Mental	To Be	HENRY LEE LONGEST		MATILDA	LONGES	ST	
ary	shou and N s ma		19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ing Address (Street an				Zip Code)
	and 2 ealth m 27 I			MEADOWOOD	ROAD, BA			
ore	ges 1 t of H if itel		Made Cremation 3 Hemoval from State	matory or other place)		9 20	Oc. Location - City or	Town, State
Baltimore,	t. Partmen rtant: njury		`4 □ Donation 5 □ Other (Specify) MEADOWRIDG			2005	BALTIMORE	, MD
Ba	Deparential Depare		21. Signature of Funeral Service Licensee	2. Name and Address 'ELLOWS, HE 00 S. HARR	ELFENBEIN	& NEWNA	M FUNERAL	HOME PA
			23a. Part1. Enter the disease, or complications that caused the death. Do not en	ter the mode of dying,	such as cardiac or r	espiratory arres	MD 21601 st,	Approximate
B	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final					Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a					1 2195
	Examiner		Sequentially list conditions, b.					
	ad sit	Examiner	cause. Enter Underlying					
	The law requires that the death certificate be axecuted ate has baen signed by the attending physician and page 2 should be detached for use as the burial-transit	xar	Course (Disease or injury) that initiated events resulting in death) Last Due to (or as a consequence of):					
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687	ifficate g phy as the		U.				1	
Box 6	es that the death certific igned by the attending p be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	⊒Ectopic pregnancy			23d. Date of de	*
о Ш	e deal	sicia		Other (specify)			Month	Day Year
P.O.	hat thind by the		Part II_Qther significant conditions contributing to death but not resulting in the u	inderlying cause given	in Part I	23a Did toha	acco usa contributa I	o the cause of death?
Records,	signe d be c	d by	Dementia	indenying cadsa given	inir aiti,			robably 4 Munknown
202	w require baen si should t	lete	HTN			24a. Was an		utopsy findings available
Re	ician: The lav certificate has rector, page 2	Completed	Peripheral Vascular Dr	SCAR		autopsy performe	ed? prior to death?	completion of cause of
ta	an: T	0	25. Was case referred to medical		26. Place of Death (0		No 1 Yes	s 2□No
	hysici nis ce I direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	nt 3 DOA Other:	4 Nursing Home	5 Residen	nce 6 Other (Spe	cify)
0	ing Pl		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?		d. Describe how	v injury occurred	
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Division of Vital	after after Direction by	Certification	4 Homicide determined 28e. Place of Injury - At home, farm, st building, efc. (Specify)	reet, factory, office	201	City or Town,		urai nobie Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, evestigation, in my opin	, date and place, and nion, death occurred	d due to the cau at the time, dat	use(s) and manner as se and place, and du	s stated. e to the cause(s)
	ro the	Me	29b. Signature and title of Cartifier	29c. License r	number	290	d. Date signed (Mont	h, Day, Year)
	->-0		* Myman ym	042	28/6	/	1/4/2005	5
			30. Name and address of person — ompleted cause of death (Item 23a) (Type,	Print)	10.	· · · · ·	1 1	
			KA Burgogne MO 55.	5 Cynwa	004 Dr.	EAST	NO NO	11) 2/60/
	Sta Registr		31. Date filed (Month, Day, Year) 32 Registrar's Signature					,
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-11		nii	ORIGINA	AL				

State of Maryland / Department of Health and Mental Hygien 005Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Rosa 2005 Bryan Hewlett January 10, 3:36 p.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center St. Mary's Leonardtown
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF Months Days Hours Yrs. Director 212-16-2326 92 June 29,1912 Maryland Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28e-f show treumetic event, the Madical Examiner hast be notified at 1 Yes XX No Director Maryland St. Mary's Scotland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23e 49520 Fresh Pond Neck Road death 1 20687 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other then "neturel", or iter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No β Specify: 3X Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Merchant Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward C. Bryan ျှ Rosa Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Leonard Bryan / Personal Rep. 19071 Three Notch RD., Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of the Importent: If ite eny injury or ot once. XXBurial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) St. Luke's Cemetery 1-15-05 Scotland, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, M00052 22955 Hollywood Road Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** docation disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Mospha Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Stroke that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No p Day 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate 2 X No 1 Yes 2 No 1 Yes To the Hospitel or Attending Physicien:

within 24 hours after death.

To the Funerel Director: Atter this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No safter death. investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m.D D (1738 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
KAE T. AUNG, 24435 MERVELL DEAN RD, MD

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - State of Ma	aryland / Depa <i>Cer</i>	artment of H tificate of L			ene 2005	01222
Ī	Physici /Medio		1. Decedent's Name (First, Middle, Last) Camilla D. Harris				2. Date of Death Month	Day Year 05 2005	3. Time of Death 6:23 P M
	Examir	ner	4a. Facility Name (If not institution, give street and number) 1903 Callaway Street		4b. City, Town, or Temple If Under 1 Year	Location of Death Hills If Under 24 Hrs.	lo Bury (Birth	4c. County of Death Prince Geo	orges
	Funeral Director		5. Social Security Number 6. Sex 1	36 (In yrs. last birthday)	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan • 06	1968 Wash	place (State or Foreign intry) ington, D.C.
	should be filed within 72 hours after deeth with the Maryland Mandala Hygiene. marked other then "naturel", or iteme 23a or 28a-f show marked other then "nature" in a marked other then "nature".	ai Director	10a. State 10b. County MD Prince Georges 10e. Street and Number 1903 Callaway Street	10c. City, Town or Lo			109	g. Citizen of What Cou USA	10d. Inside City Limits 1€ Yes 2 □ No untry?
.0036	hours after dee lural', or itame	ed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 15. Decedent's Education	10		spanic Origin? (Spen, Mexican, Puerto		14. Race - Amer Black, White Specify: B1a	ck
Baltimore, Maryland 21215-0036	filed within 72 Hygiene. other then "nai	Be Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5 4 yrs	(Give	ountant	turing most of worki	I I	Sb. Kind of Business/li Dept. of Ho Jrban Devel aiden Sumame)	ousing &
rylan	d 2 should be th and Mental 7 is marked of treumatic ev	To B	Daniel M. Wilkerson 19a. Informant's Name/Relationship (Type, Print)	19h Mailin	n Address (Street a		Thompki	ns City or Town, State, Zi	in Codel
e, Ma	ss 1 and 2 sho of Health and litem 27 Is my r other treums		Kevin M. Harris/Husband		Callaway	Street Te	emple Hil	1s, MD. 20)748
altimor	permit. Pages Department of I Importent: If it any injury or o ance.		1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	HArmony Me	emorial P . Name and Addres	ark 1-11-	-05 LA shall's I	ndover, MD Funeral Hor	ne
	805 5 8		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not ente				on, D.C. 20	OO11 Approximate Interval Between
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	ary Embolus a consequence of):	5				Onset and Death
3760,	ate be executed hysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Line of identifying Cause (Disease or injury that initiated events	Adenocarcinal consequence of):	noma				
O. Box 6	death certiff e attending d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deliv Month	ery Day Year
ecords, P.	gned be de	by	Part II. Other significant conditions contributing to death bu	t not resulting in the un	nderlying cause give	en in Part I.		cco use contribute to t	the cause of death?
r	9 4	Completed	Of Was are aforest to redical				24a. Was an autopsy performe	prior to co death?	opsy findings available impletion of cause of
ot VII	Physicien: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 1 ☐ Inpatie			4 Nursing Hor	me 5⊠ Resid <i>e</i> nd	ce 6 □Other (Specia	(y)
	Attending or death. ector: After by the fune	ertification:	27. Manner of Death 1 🛣 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injur (Month, Day) 5 Could not be determined 28b. Place of Injur (2001) 28c. Place of Injur (2001)	ry - At home, farm, stre		fes 2 □ No	28d. Describe how 28f. Location (Stre. City or Town,	et and Number or Rura	al Route Number,
5	spitel hours merel y fiiled	O	29a. Certifier (Check only 2 Medical Examiner: On the basis of	f my knowledge, death					
	To the Hos within 24 h To the Fur completely	Medicai	one) and manner sta		29c. License			. Date signed (Month,	
D	(5)		30. Name and address of person who completed cause of de	ath /Itam 22a) /Time /	207	740	1	L - 7 - 05	
1	-6		Gerard Harris, M.D. 10	6 Irving St		4200 Wash	nington,	D.C. 20010	
	Sta Registr		JAN 0 7 2005	r's Signature	W				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1:20^{a M} 03, MARY BEATRICE HINMAN Jan. 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) **Examiner** Pocomoke City Worcester Hartley Hall Nursing Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 86 July 28, 1918 Virginia Director 218-09-5711 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Heatih and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 14 Yes 2 □ No MD Pocomoke City Worcester Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21851 USA 1006 Market Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail 12 Sales 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Margaret Wallace Parks William Edward Hinman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3850 Devenshire Dr., Salisbury, MD 21804 Carol Lynne Ollendike (cousin) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 월 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/6/2005 First Baptist Cemetery Pocomoke City, MD `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licenses 22. Name and Address of Facility Holloway Melson Funeral Home, P.A. Michael 103 Linden Ave., Pocomoke City, MD 21851 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Vass Priysiciar resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Be Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year detached for in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2.21No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Turursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death.
To the Funerel Director: A completely filled in by the fr 2 Accident by the ! 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 054422 30. Name and address of person who completed cause of death (Item) 23a) (Type, Print) MD 21851 5+ rocomo 32. Begistrar's Signature 04 2005 State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 1 tem#11 per Inf (840 / 1/0) TI State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month (**Physician** 05 65 brook 2238 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury NICOMICO 0)1 tal nice If Under 24 Hrs. If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 → M 2 □ F 218-20-5925 Director 10-30-25 MAR Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" any injury or other traumatic excessions. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director DOMERSE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ENTON 28479 21853 Kd USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes. 2 ☐ No If Yes, Give Dock. 1944 Year or Dates: JUNE 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3 Widowed 4 Divorced AMRRICAL Ro 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College,(1-4or 5+) SBRVICE 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elin Holber WilbROOK GERTRUDE SR DAM JA. 19b. Mailing Address (Street and Number or Ryral Route Number, City of Town, State, Zip Code) 19a, Informant Name/Relationship (Type, Print) 28479 BNOW ANNE Md, 21853 7 E MAN 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Wethod of Disposition Date 1 Burial 2 Cremation 3 Removal from State 05 LAND CEM 4 Donation 5 Other (Specify) MALY VA 22. Name and Address of Facility 21. Signature of uneral Service Licensee ANNB 30479 23a. Part1. Enter-the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Non small cell lung Cources Immediate Cause (Final disease or condition resulting in death) /Medical year Examiner Due to (or as a consequence of) Physiclan/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1LI Yes 3KNo 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 Z No 5 ☐ Residence Other (Specify) Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident Injury To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) APPOWWOOD

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		1 _ State		partment of Health and ertificate of Death		2000 01220
		Registrar 1. Decedent's Name (First, Middle, Last)		eruncale of Dealit	Reg.	No. 3. Time of Death
Physici	an		E-D		Month	Day Year 90 0 - M
/Medic		HOLMES LAVIER HALI 4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Dea	Danuary	4c. County of Death
Examir	ier	WASHINGTON COUNTY HOSE		HAGERSTOWN	I I	WASHINGTON
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hr		
Director		217-18-7705	78 Yrs.	Months Days Hours Mir	JULY 8, 1	926 MARYLAND
pu .		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
larylan show	ă		Too. Oxy, Town or		DO	1 ☐ Yes 2 ☒ No
ith the Maryla or 28a-f shov	Director	MARYLAND WASHINGTON 10e. Street and Number		BOONSBO		Citizen of What Country?
th with	Ö	8251 OLD NATIONAL PIKE	7	21713		U.S.A.
ter death Itams 2:	Funerai	11 Marital Status 12. Was E		Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,
ours after death war air, or itams 23a	F	1 Never Married 2 Married 1 XY	es 2□No [943-	1 ☐ Yes 2 ☑ No Specify:	no Hican, etc.)	Black, White, etc.
	d by	3 ⊠ Widowed 4 □ Divorced Year	or Dates: 1946			Specify: WHITE
natu Mica	ete	15. Decedent's Education (Specify only highest grade complete	ed) (G	cedent's Usual Occupation ive kind of work done during most of w a. DO NOT use retired)	orking 16b	. Kind of Business/Industry
be filed within 72 hattat Hygiene. d other then "netu	Completed	Elementary/Secondary (0-12) Colleg	ge (1-4or 5+)	SERVICE TECHNICIA	NT T	ELEPHONE COMPANY
Hygir Hygir ant.	Ö	17. Father's Name (First, Middle, Last)			ame (First, Middle, Maid	
should be filed and Mental Hygi marked othar matic avant, I	To B	GEORGE WASHINGTON HALLE	ER	CATHER	INE BAKER	
a y rain a filed with and Mental Hygiene is marked othar that aumatic avant, Ital	-	19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street and Number or F	Rural Route Number, Cit	ty or Town, State, Zip Code)
		MELISSA STUBBLEFIELD/DA	AUGHTER 238	SPIRIT HOLLOW DRI	VE, WINCHES	STER, VIRGINIA 22603
es 1 and 3 of Health filam 27 or other tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fr		sposition (Name of rematory or other place)	Date 20c.	Location - City or Town, State
Pages ment of I		'4 □Donation 5 □ Other (Specify)		EN CEMETERY 01/	08/2005 HA	GERSTOWN, MARYLAND
permit Pages Department of Important: if it any Injury or once.		21. Signature of Flureral Service Libensee	Paul M. Dean	22. Name and Address of Facility BAST FUNERAL HOME		National Pike
7 905 9 9		Can II / low				, Maryland 21713
		23a. Part1. Enter the dise in or complications the shock, or heart failure. List only one cause of	nat caused the death. Do not	enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical	11	Immediate Cause (Final disease or condition resulting in death)	berstelling	Kneuman	ia	lucek.
Examiner		Due	to (or as a consequence of):	.120:	Lenzale	
	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consequence of):	ias men	cen 200	/ Week
cuted Id ansit	Examiner	Cause (Disease or injury that initiated events				
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he death certifical	/Me	IF FEMALE: 23c If was	outcome of pregnancy			004 0-4-4-15
atten for u	cian	in the past 12 months?	ve birth 2 ☐ Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
the d	Physician/Med		nknown			
v requires that the deben signed by the	by Pi	Part II. Dther significant conditions contributing to	to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
w require been sig should b		Chronic Supr	pho who	llukemia	1 ☐ Yes	2 N 3 Probably 4 Unknown
law re as ber 2 sho	Completed	\	\		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
The The ate has page	Com				performed	2' death? No 1 ☐ Yes 2 ☐ No
sician: The law scriticate has be lirector, page 2 s	Be (25. Was case referred to medical examiner?			eath (Check only one)	
hysi this c	ြိ		Inpatient 2 ER/Outpa ate of Injury 28b. Time		Home 5 Residence	
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Attan deatl ctor: y the	fica	3 Suicide 6 Could not be 28e. P	lace of Injury - At home, farm,		28f, Location (Street	and Number or Rural Route Number,
a after i Dira	Certification:	4 Homicide	uilding, etc. (Specify)		City or Town, St	ate)
To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medicai ((Check only 2 Medical Examinar: On the		eath occurred at the time, date and place r investigation, in my opinion, death occ		
o the	Mec	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)
F 5 F 0		MINHO	M - M	DILLI,	13 6	MOULDARCE
		30. Name and address of person who completed	cause of death (Item 23a) (Ty	pe, Print)	.1	21747
DH 15+1		Hind Hound	an, MD;	1130 OPAL	ct. Hou	gerstown, MD
Sta Regist		31. Date filed (Month Pay Year) 5 2005	2. Registrar's Signature	1.4.	1	V

			For State Registrar	State of Maryl			of Heal		F	Reg. No. 4 UU	5 01226
	Physici /Medic		1. Decedent's Name (First, Middle, La PATRICIA MAE	HARTSOCK		1			2. Date of Dea Month JANUA	RY 7, 200)5 8:15 P ^M
	Examin	er	4a. Fecifity Name (If not institution, gives 2242 BRIDAL PA				own, or Loca ALDOR	tion of Death		4c. County of Dec	
	Funeral Director		5. Social Security Number 6. S 578-48-8940	Sex 7. Age (In)	yrs. last birthday) 59 Yrs.	If Under Months	Year If U	nder 24 Hrs. ours Min.	8. Date of Birt (Month, Da)	v, Year) C	rthplace (State or Foreign Country)
	the Maryland 28a-f show notified at	tor	Usuat Residence of Decedent 10a. State 10b. County MARYLAND CHA	RLES	City, Town or Le						10d. Inside City Limits 1 ☐ Yes XIXNo
	with the	Director	10e. Street and Number			10f. Zip				10g. Citizen of What C	
980	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Itams 23a or 28a-f show ant, the Medical Examinar must be notilled at	by Funeral	2242 BRIDAL PA 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	TH DRIVE 12. Was Decedent Ever i Armed Forces? 1 □ Yes 2 ☒ No ff Yes, Give Year or Dates:		Was Decedor ff Yes, special	Ĺ	ic Origin? (Spe exican, Puerto	ocify Yes or No- Rican, etc.)	U . S . 14. Race - Am Black, Wh Specify: W F	erican Indian, ite, etc.
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	filed with Hygiene. other then	Completed	Efementary/Secondary (0-12)	Cottege (1-4or 5+)		[EMAK]	ER			OWN F	IOME
Maryland	ed at a s	Be	17. Father's Name (First, Middle, Last OSCAR L. CROWE)					(First, Middle,	Maiden Sumame)	
aryl	d 2 should th and Men 7 is marke traumatic	T _o	19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address				or, City or Town, State,	Zip Code)
	1 and		DEBRA SCOTT - 20a. Method of Disposition		204 b. Place of Dispo			_	203,II	NDIAN HEA	
TOF	Pages nent of h ant: If its ury or of		to Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	cemetery, cre	matory or oti	ner place)			CHELTENH	
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lice	nsee M00479	0 2 R	2. Name and AYMOI	Address of F	Facility NERAL	SERVI	CE, PA	,
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	w requires that been signed b should be deta	by	Part II. Other significent conditions	contributing to death but not	resulting in the u	inderlying ca	use given in f	Part I.	23e. Did to	obacco use contribute	to the cause of death? Probably 4 Unknown
of Vital Records,	nysician: The law rec nis certificete has bee i director, page 2 shot	Completed						- face and the short state of th	24a. Was autop	sy prior to death?	
ig.	ician: Th certificete rector, pag	Be C	25. Was case referred to medical examiner?					Place of Death	(Check only o		
of V	Physic this co	၉	1 Yes 2 No		2 ER/Outpatie					lence 6 Other (Spa	ecify)
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	λ	W	29b. Signature and title of certifier	Volut		0	License num	1031		29d. Date signed. (Mon	
	10		30. Name and address of person who MICHAEL LEATHE	completed cause of death (ME CE	Numero o	э л г э.	00 1481 00	DD MD 2000
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's S		<i>.</i> <u></u>	VII CE	TA T E L(\)	<u> </u>	<u>UZ , WALDU</u> E	CF,MU 20604

			For State Registrar	State	of Marylar		artment rtificate			and Mo		giene Reg. No.	200	5	012	227
	- Planeta	6.0	1. Decedent's Name (First, Middle	e, Last)							2. Date of De. Month	ath Day	Y 4	ear	3. Time of	Death
	Physici: /Medic		Anne Marie Ia	nnone			1				Januar	y 2,	2005		1:15	ам
	Examin	ęr	4a. Facility Name (If not institution						Location of	of Death		4c.	County of I		. 2011	
e.,	Α,		Montgomery Ge 5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	If Under	ney 1 Year	If Under	24 Hrs.	8. Date of Birt	h	Mont		ca (State o	or Foreign
	Funeral Director		163-24-1934	1 ☐ M 2 🖾 F		'3 Yrs.	Months	Days	Hours	Min.	(Month Da April 1	9 , Year)	.931		nsylv	
			Usual Residence of Decedent				1				-					
	irylan ihow	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10	d. Inside Ci	
	sa-f s	Directo		nce Georg	ge's	Adel										2 🔯 No
	or 2		10e. Street and Number				10f. Zip				10g. Citizen of What Country?					
	18 238	Funeral	10822 Pleasant		CLVE cedent Ever in U	S 13		783	isnanic Orio	nin? (Sne	cify Yes or No		USA 14. Race -	America	n Indian.	
10	iter d	Fun	1 ☐ Never Married 2 ☐ Mar	Armed F	orces?		It Yes, spec	ify Cuba	n, Mexican	, Puerto F	Rican, etc.)			White, e		
936	ursal al', or	by	3 ☐Widowed 4 ☐ Divorced	If Yes. G	ive		1 ☐ Yes 2	2⁴⊡ No	Specify:				Specify:	Whit	:e	
21215-0036	u within 72 hours after death with the Maryland jiene. Ithan *natural', or Itams 23a or 28a-f show It a Madical Evantrat roual be Incilliad at	Completed		nt's Education est grade completed	")	16a. Dece	dent's Usua	l Occupa	ation du <i>ring m</i> osi	t of workin	na	16b. Ki	nd of Busin	ess/Indu	ıstry	
21	within ene. than	nple	Elementary/Secondary (0-12)		(1-4or 5+)	1	kind of wor DO NOT us)			0	wn Ho			
2			I 2 17. Father's Name (First, Middle,	(act)		по	memak	er	18 Mothe	ar's Name	(First, Middle,			me		
anc	0 = 0 %	Be	John W. Yarri								nister	maidon	o amamo,			
Maryland	should be and Mental a marked o	2	19a. Informant's Name/Relations	3		19b. Maili	ng Address	(Street a			Route Number	er, City o	r Town, Sta	te, Zip (Code)	
S	lith ar 27 is r trau		Anne Crowe/ Da	Anne Crowe/ Daughter 729 West Cumberland a. Method of Disposition 20b. Place of Disposition (Name of							ad, Bl	uefi	eld,	WV 2	4701	
ē,	ages 1 and 2 should b ont of Health and Ments it: If item 27 is marked y prothar traumatic e	Ì	20a. Method of Disposition	1 Surial 2 Cremation 3 Removal from State cemetery, crematory or other place)							ry 5	20c. Lo	cation - Cit	y or Tov	n, State	
E	Page nent c int: If			4 Donation 5 Other (Specify) Gate of Heaven Cemetery							5	Sil	ver S	prin	ıg, Ma	rylan
Baltimore,	permit. Pages 'Department of H Important: If ite any injury or of once.			Signature of Funeral Service Licensee Typical Typical Laboratory 22. Name and Address of Facility Francis J. Coll. 500 University E								Hom	ne Ind r Spr	ing,	MD 2	20901
			23a. Part 1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one cause on	caused the deal	th. Do not en	ter the mod	e of dying	g, such as	cardiac o	r respiratory a	rrest,			Approximat Interval Bet	ween
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	/Medical Examiner		resulting in death)	Due to	o (or as a consec	quence of):	197	1						7		
	- Adminion	e e	Sequentially list conditions,	b. Due to	o (or as Tyonseo	quence of):	chen	-				-		24	-	
	nsit	n lu	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<	Atm		Rib	n U	laste	a .						
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tal		a	25. Was case referred to medical	al .					26 Place	of Death	(Check only of	2 No		Yes 2	2 □ No	
Ξ	Physician: this certific	To B	examiner?	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DC	Cthe	00		ne 5□Resi		3 □Other (Specify)		
	ng Ph ter th neral		27 Manner of Death Natural 5 ☐ Pendi	/A Ac	e of Injury onth, Day Year)	28b. Time o	of 2	8c. Injury Work	y at k?	2	8d. Describe l	how injur	y occurred			
ioi	Vttendir death. ctor: Af y the fu	atic	2 Accident invest	igation			М	1 🗆 '	Yes 2	-						
Division	after de	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 28e. Plac	ce of Injury - At h ding, etc. <i>(Speci</i>	ome, farm, st	reet, factory	, office		2	281. Location (: City or To			or Rural	Route Num	nber,
	pital ours a seral C	Ce	29a. Certifier Certifyi	ng Physician: To t	no bast of my kn	owledge deat	h courred	at the tim	no date an	d place a	and due to the	C3/150/5/	and mann	or ac eta	ted	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Diractor: After th completely filled in by the funeral	edicai	(Check only 2 Medice	Examinar: On the	basis of examination of stated.	ation and/or in	vestigation.	in my o	pinion, dea	th occurre	ed at the time,	date and	place, and	due to	the cause(s	5)
	To the To the Complex	Me	29b. Signature and title of certifi	er .	a 1	0			e number	2		29d. Dat	e signed (A	Aonth, D	ay, Year)	
	7		▶ Wilkins	an J.	Vino	la		D4	528	5 0		Jan	mary	di	200	5
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WT NINDA, 344 University Bwd#113, Silver spring, Md 200						2090	1							
		State 31. Date filed (Month, Day, Year) 32. Fogistrar's Signatur														
	Regist	rar	JEN U	JAN 0 4 2005 Blown & F												

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiere Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** EDWIN LAVERNE JONES, SR. 5,2005 2330 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Easton Hospital Memorial If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month Day, Year) APR 7 1926 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F MARYLAND Director 215-20-0548 78 Yrs. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 🎾 No PRESTON MD CAROLINE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral 20820 DOVER BRIDGE RD 21655 USA death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2☐ Married 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) EQUIPMENT OPERATOR STATE HIGHWAY ADMIN. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked of Pages 1 and 2 should be J. WALTER JONES LEONA HADDAWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 i BETTY JOY JONES/WIFE 20820 DOVER BRIDGE RD., PRESTON, MD 21655 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 0 1 Durial 2 Cremation 3 Removal from State Department of Importent; if any injury or pace. EAST NEW MARKET CEMETERY 1-12-2005 EAST NEW MARKET, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JUSEPH M Ostrovski 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician weel /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): physician and s the burial-transit certificate be executed Due to or s a consequence of): resulting in death) Last Physician/Medical as attending | IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at d be detached fo 4 Pregnant at time of death 5 ☐ Other (specify) Yes 2 2No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s erbitue autopsy performed? 2 No 1 ☐ Yes 2 ₺ No 1 Yes director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes No

certificate or Attending Physician: the funeral s after death.

Edwin L. Jones

1 Inpatient 2 ☐ ER/Outpatient

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

Houde 31. Date filed (Month, Day, Year)

5 Pending

investigation

6 Could not be determined

27 Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who co leted cause of death (Item 23a) (Type, Print)

State Registrar

32. Registrar's Signature

within 24 hours a

To the Funeral E

completely filled i To the Hospitei

Medical

			1- State of Maryland / De State of Maryland / De State of Maryland / De Registrar		
	Physici /Medio		1. Decedent's Name (First, Middle, Last) David Jermaine Jordan,	Mo	tate of Death Ann. 8 , $\stackrel{\text{Day}}{2005}$ $\stackrel{\text{Year}}{0}$ 0857 A_{M}
2	Examin		4a. Facility Name (If not institution, give street and number) ROUTE: # 257	4b. City, Town, or Location of Death ROCK POINT	4c. County of Death CHARLES
Ī	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 □ F 7. Age (In yrs. last birthda 2 ≥ 7 × 7 × 7 × 7 × 7 × 7 × 7 × 7 × 7 × 7	Months Days Hours Min. (Mo	ate of Birth (State or Foreign Country) 9. Birthplace (State or Foreign Country) Maryland Maryland
	aryland show	<u></u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show r must be notified at	Director	Maryland Saint Mary's Mechan 10e. Street and Number	Lcsville 10f. Zip Code	1 ☐ Yes 2 📉 No
	23a o	ralD	37398 East Lakeland Drive	20659	USA
920		by Funeral	11. Maritat Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 No 1 Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Specify Ye ff Yes, specify Cuban, Mexican, Puerto Rican, 1 ☐ Yes 2 ☒ No Specify: 	fes or No- h, etc.) 14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036	"natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	pedent's Usual Occupation re kind of work done during most of working . DO NOT use retired)	16b. Kind of Business/Industry
121	led witl lygiene her the	Com	10 17. Father's Name (First, Middle, Last)	Waterman	Seafood
lanc	ild be fi lental F ked ot Ic svei	To Be	David Allen Jordan	Blanche Ar	st, Middle, Maiden Sumame)
Aary	2 shou and M Is mar	-		iling Address (Street and Number or Rural Route	
	s 1 end f Health ftem 27 other t		20a, Method of Disposition 20b, Place of Dis	292 Cherryfield Road, Drayde position (Name of Date	20c. Location - City or Town, State
Baltimore,	permit. Pages 1 end 2 should be filed within Department of Health and Mental Hyglene. Importent; if Item 27 is marked other then any Injury or other treumatic event, It a Me ODE.		'4 □Donation 5 □Other (Specify) St. Mark's	Gematory or other place) January Cemetery 14, 2005	
Ball	Departi Departi Import any In		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Mattingley-Gardiner Funeral 2.0. Box 270, Leonardtown, M	Home, P.A. Maryland 20650
	Physician /Medical Examiner		23a. Part / Enter the disease, or complications that caused the death. Do not death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate		piratory arrest, Approximate Interval Between Onset and Death
68760,	icate be executed physicien and s the burial-transit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Error Uncertains Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d		
P.O. Box 6	at the death certific by the ettending p tached for use as	Physician/Me		B □Ectopic pregnancy S □ Other (specify)	23d. Date of delivery Month Day Year
ords, P	w requires that been signed be should be det	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
Vital Records,	: The law ricate hes be	Completed			24a. Was an autopsy autopsy findings available prior to completion of cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 24c. Was an autopsy findings available prior to completion of cause of death?
Division of Vita	Attending Phyelcien: The law requires that the death certificate be executed ar death. ector: After this certificate hes been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transil	Certification: To Be	25. Was case referred to medical examiner? **Per 2	of (28c. Injury at Work? A M 1 XYes 250 No. 1	Describe how injury occurred Describe how injury occurred
D	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	cal Cer	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place, and due	ue to the cause(s) and manner as stated.
	To the h within 24 To the f complete	Medical	29b. Signature and title of certifier	29cd icense number	29d. Date signed (Month, Day, Year)
L	m 6		30. Name and address of person who completed cause of death (Item 23a) (Type 1111 P	e, Print) FNN STREET BALTIMORE	JAN. 9, 2005
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	de de)
	Registr	ar	JAN 1 1 2005		

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	partment of F		and Mer		ene	005	01221
			Decedent's Name (First, Middle, La	ast)				2.	Date of Death	1	000	3. Time of Death
	Physici		Joseph Louis Knott-	Currio				\	Month	Day 1'2	Year 2005	03:01 AM
	/Medic Examir		4a Facility Name (#not institution, gi		7)	4b. City, Town, or	r Location o		ototoett y		unty of Death	1
		<u>.</u>	The chus H	opline.	Hospial	Batt	t. mon	co C	144			
2	Funeral				ge (In yrs. last birthda	y) If Under 1 Year Months Days	If Under 2	24 Hrs. R	Date of Birth (Month, Day,	Vear)	9. Birth	place (State or Foreign intry)
Ŀ	Director		216-71-6286	1 X M 2□F	Yrs.	22	riours		ec. 21, 2		Mary	
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						10d Incide City Limite
	sho	7			Too. Oity, Town of	Location						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the N	ect	Maryland St. Mary 10e. Street and Number	's	C1emer	1				0:1:	-6114	
	E or	Ö				10f. Zip Code			"		of What Cou	intry /
	be filed within 72 hours after death with the Maryland hat Hygiene. ed other than "netural", or tiems 23e or 28e-f show event, the Medical Examinar must be notified at	Funeral Director	24461 Budds Creek Ro	12. Was Deceden	t Ever in U.S. 13	20624 . Was Decedent of H	lispanic Orig	nin? (Specifi	y Yes or No-	USA	Race - Amer	ican Indian
	iter d	Fun	1 Never Married 2 Married	Armed Forces	?	If Yes, specify Cuba	an, Mexican	, Puerto Ric	an, etc.)	1	Black, White	
99	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	1	1 ☐ Yes 2 🛣 No	Specify:			Sp	ecify: Whi	te
21215-0036	2 ho	Completed	15. Decedent's E			edent's Usual Occup			_1	6b. Kind	of Business/I	ndustry
215	C 100	ple	(Specify only highest gi	College (1-4o	life	re kind of work done of DO NOT use retired	auring most d)	or working				
21	filed wit Hygiene other the	Con	0			N/A				N/	'A	
p	be file ta! Hy d oth	Be (17. Father's Name (First, Middle, Las	t)			18. Mothe	r's Name (F	irst, Middle, M	laiden Su	тате)	
yla	S should be filed withir and Mental Hygiene. Is marked other than aumatic event, The M.	0	Carroll Richard Cur					e Lynn				
Maryland	s 1 and 2 should f Health and Men itam 27 is marke other traumatic	7.3	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Street	an <i>d Numb</i> e	r or Rural R	oute Number,	City or To	own, State, Zi	ip Code)
	1 and Health am 27		Nicole Lynn Knott/M	other		Budds Creel	k Road,					
0	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [☐Removal from Stat	e cemetery, ci	position (Name of rematory or other place	-	Date			ion - City or T	
Ë	Pa tmen tant: jury		' 4 Donation 5 Dother (Spec	ify)	Charles Me	emorial Garde		an. 14,			dtown,M	
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Lie	Larde	ner	P. O. Box	ss of Facility 270, L	y Mattir eonardt	ngley-Gan cown, Man	rdiner yland	Funera 20650	l Home, P.A.
	11.		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that cause	ed the death. Do not e	nter the mode of dyin	ng, such as	cardiac or re	espiratory arre	st,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	3.4 4.4	System	Organ		lure				Onset and Death
	/Medical		resulting in death)	d	s a consequence of):	017001						01. (01/3
	Examiner		Sequentially list conditions,	b. Prema	aturity							21 days
	p #	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	2	s a consequence of):							2.
	ecute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	U		stress !	Dynd	nome	-		13	di days
00	be executed sician and burial-transit	E	resulting in death) cast	4 4	s a consequence of):							21 days
8760	cate be ex physician the buria	dical		d. Hyp	o tensior							011 62142
9	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	0	IF FEMALE:	220 16 von outcom	a of organization							
Box	attend for us	Physician/M	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	☐Ectopic pregnancy	/			23d	 Date of deliving Month 	rery Day Year
o.	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	at time of death	Cottlet (specify)						
<u>C</u>	res that the de signed by the signed by		Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause giv	en in Part I.		23e. Did tob	acco use	contribute to	the cause of death?
ds	sign d be	d b	Preumo peritor	reum.	Intraven	ricular	Hemore	hage.	1 ☐ Ye	s 2 1 N	lo 3∏Pro	babiy 4 Unknown
Ö	w require been sig should b	ete		indi Liasis	,			— J '	040 146		45. 144	
Records,	has ye 2	Completed by			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	100			24a. Was an autopsy perform	ed2	prior to co	opsy findings available ompletion of cause of
a	ician: The t		Thrombucytop	enia					1 ☐ Yes 2	No No	1 🗆 Yes	2 No
Vital	ysician: is certific director,	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 😿 No	Hospital: 1 Minpa		ent 3 DOA Oth			heck only one			
Division of	Phys	To To	27. Manner of Death	28a. Date of In (Month, D		one of bon	,		5 Resider			ity)
0	ding I th. : After funer	tlor	1,XNatural 5 ☐ Pending 2 ☐ Accident investigation		Pay Year) Injury		k? Yes 2 □1	No				
/isi	Attar dea actor	Certification;	3 ☐ Suicide 6 ☐ Could not	d 28e. Place of I	njury - At home, farm,	street, factory, office		28f.			lumber or Rui	al Route Number,
ā	after after Dira	erti	4 Homicide	building,	etc. (Specify)				City or Town,	State)		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying F	Physician: To the bes	st of my knowledge, de	ath occurred at the tir	me, date and	d place, and	I due to the ca	use(s) an	d manner as	stated.
	na Ho 124 l na Fu	Medical	(Check only 2 Medical Exa	miner: On the basis and manner:	of examination and/or stated.	investigation, in my o	pinion, deat	th occurred	at the time, da	te and pla	ace, and due	to the cause(s)
	To the To the Comp	×	29b. Signature and title of certifier		M	29c. Licens				d. Date s	igned (Month	. Day, Year)
	100		1 Joshua	1 & how	C LIT	KE	2.0	000	1	Sanu	an 1	2,2005
	Dr.1		30. Name and address of person who	o completed cause of		e, Print)	^	-				2. 2005 MD 21287
_				HON	600 N	erth We	olle	200 Stre	et:	Balt	imore	MD 3138
	Sta		31. Date filed (Month, Day, Year)	4 2005 Regis	dar's Signature	Annatt o						
	Regist	IEI/	Alaka T	*	The state of the s	A STATE OF THE STATE OF						

amend item#17, per Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 5 1- State amend item#1, perMD, G840, 2/11/Optilitate of Death 1. Decedent's Name (First, Middle, Last) Abdul R Kamara 2, Date of Death 3. Time of Death **Physician** Month Year ABDUL KAMARA JR 9.50 lanuary 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S DOCTOR'S COMMUNITY HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, August 7 Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1X3 M 2□ F Director 220-19-3817 57 Yrs. 1947 Sierre Leone W. Usual Residence of Decedent 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 71s marked other than "natural", or Iteme 23a or 28a-1 show traumatic svent, tre Medical Examinar must be notified at MD PRINCE GEORGE'S CAPITAL HEIGHTS 1X Yes 2 No Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 U.S.A. 6610 Arlene Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2K Married altimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 72 h and Mental Hygiene. 7 Is marked other thsn "ne Elementary/Secondary (0-12) College (1-4or 5+) 4 yrs Security Officer Private 17. Father's Name (First, Middle, Last)
Andu Kamara
Abdui R. Kamara 18. Mother's Name (First, Middle, Maiden Sumame) Be Kamara Sr. Isatu Kamara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Important: If Item 27 Is m any Injury or other traum once. Madinatu Kamara/Wife 6610 Arlene Drive Capital Heights, Maryland 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington 1/7/2005 Adelphi, Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20743 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hepatocellular Immediate Cause (Final **Physician** carcinoma disease or condition resulting in death) month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at id be detached for 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 0 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performe 2. No 2K No 1 Yes To the Hospitel or Attending Physician: within 24 hours effer death.

To the Funerel Director: After this activity funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 Pending investigation М 1 Yes 2 No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 - Homicide 29a. Certifier Techtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 53829 ranny - GREENBELT, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENWAY CONTREE DR 30,772 7525 M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 6 2005 JAN 0 Registrar

			For State Registrar	State of Mar	ryland / Depa	artment of F	lealth and M		ene2 0 0 5	01233
			Decedent's Name (First, Middle,	Last)				2. Date of Death	1	3. Time of Death
П	Physici		Jimmie	Lee	Koon			Jan.4	2005	11:15a ^M
	/Medic Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	
			Holy Cross	Hospital		Silv	er Snri	าต	Mont	gomory.
	Funeral		5. Social Security Number	5. Sex 7. Age ((In yrs. last birthday)	If Under 1 Year Months Days	er Sprin If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bi	GOMERY Implace (State or Foreign ountry)
L.	Director		212-22-2262	1\2 M 2□F 7	79 Yrs.	Wichitis Days	110013	7/25/1	925 U	osher Co,WV
	and *		Usual Residence of Decedent 10a, State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Aaryla F sho	ō	WV Lewi		Jane					1 ☑ Yes 2 ☐ No
	28e-	Director	10e. Street and Number	3	vane	10f. Zip Code		10	g. Citizen of What C	ountry?
	with 3e or	Ö	2122 Broad	Run Rd.			378		US	
	itied within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Items 23e or 28e-f show ent, the Medical Examiner must be notified at	Funerai	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.		dispanic Origin? (Spi an, Mexican, Puerto	ecify Yes or No-	14. Race - Am	
ഥ	or Ite	F	1 Never Married 2 Marrie	Armed Forces? d 1 ☑ Yes 2 ☐ No If Yes, Give	1943-			Rican, etc.)	Black, Wh	te, etc.
ğ	rel', c	l by	3	Year or Dates:	1946	1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
5-0	72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give	edent's Usual Occup e kind of work done	oation during most of work d)	ing 1	6b, Kind of Business	/Industry
2	Aithin Ne.	mpi	Elementary/Secondary (0-12)	College (1-4or 5+))					
'n	iled v lygie her t		17. Father's Name (First, Middle, L	act)	S	Supervis	18. Mother's Name	. /First Middle A	Constru	ction
and	m - 0 %	Be	Hoy Lafayet				Mae De		alderi Surrame)	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "neture!, or Items 23e or 28e-f show eny injury or other treumstic event, the Medical Examiner must be notified at once.	^L	19a. Informant's Name/Relationshi		19b. Maili	ing Address (Street			City or Town, State,	Zin Codel
<u>s</u>	nd 2 s lith ar 27 is		Jackie Sprun		1.		Run Rd.		Lew, WV	
ē,	s 1 ar f Hea item other		20a. Method of Disposition	<u> </u>	20b. Place of Dispo				Oc. Location - City o	
e E	Page: ent o		1 Burial 2 ☐ Cremation 1 Donation 5 ☐ Other (Sp.				tery1/07	7/05	Pruntyto	wn WV
Baltimore,	mit.		21. Signature of Funeral Service I	4						, ,, , ,
Ö	P. C.		Hilly 10 K	walds	9	241 Col	.RINALDI umbia B	. FUNER.	AL SERVI ver Spri	CE,PA ng,Md20910
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	omplications that caused the	he death. Do not en	ter the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Pnysician	i n	Immediate Cause (Final disease or condition	Calhacosons	STOREST COSTS					Onset and Death
	/Medical		resulting in death)	a. Due to (or as a	cation P consequence of):	neumonı	a			
В	Examiner		Sequentially list conditions,	b. MRSA	Pneumon consequence of):	1a				
	be fis	ine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a	consequence of):					
	xecut and I-tran	Examiner	that initiated events resulting in death) Last	c. <u>Hyper</u>	rtension					
8760,	death certificate be executed e attending physician and id for use as the burial-transit			,	orovascu	lar Acc	ident			
687	ificate g phys as the	Physician/Medical		0	<u> </u>	Tul nec	100110			
Box	death certifica attending pl	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		75			23d. Date of de	livery
	ie deat the attr hed for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify) _	у		Month	Day Year
P.0	that the di ed by the detached	hy	9 🗆 Unknown							
Ś	es pe pe	by	Part II. Other significant condition	is contributing to death but	not resulting in the u	underlying cause giv	ven in Part I.			to the cause of death?
ord	w requir been si should	ted						1 L Ye	s 2⊠No 3∏F	robably 4 Unknown
Vital Record	e law has b	ompleted						24a. Was ar autopsy	prior to	utopsy findings available completion of cause of
<u>=</u>		O						perform 1 ☐ Yes 2	ied? death? No 1 ☐ Ye	s 2 No
Ž.	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		-t 20 DOA Ott	26. Place of Deat			
of		T.	1 Yes 2 No 27. Manner of Death	13 Inpatient 28a. Date of Injury		HIL 3 DOA	4 Nursing no	me 5 \subseteq Resider 28d. Describe hor	nce 6 □Other (Sp. w injury occurred	ecify)
on	Attending I r death. Bctor: After by the funer	tior	1 XNatural 5 ☐ Pending 2 ☐ Accident investig		Year) Injury	of 28c. Injur Wood M 1	rk? Yes 2 □No		, ,	
Division	or Attendated after death	ifica	3 ☐ Suicide 6 ☐ Could not determine	and 28e. Place of injury	y - At home, farm, st	treet, factory, office		28f. Location (Str	eet and Number or F	lural Route Number,
	iel or A s after el Direct	Certification:	4 [Homolde	building, etc.	(Эрөспу)			City or Town	, Sidle)	
	To the Hospitel or Attenwithin 24 hours after deat. To the Funerel Director:	edicai	29a. Certifier 1 Certifying	Physician: To the best of xaminer: On the basis of e	my knowledge, dea	th occurred at the til	me, date and place,	and due to the ca	use(s) and manner a	s stated.
	To the h within 24 To the f complete	Medi	one)	and manner state	ed.					
1	Tol		29b. Signature and title of certifier	· CIAAMII	M	29c. Licens D5	9284	28	d. Date signed (Mor	4/200
•	5		20 Name and address	to completed as a first	ath (Itom 00-) T				170	. (2 0 3
			30. Name and address of person v				Cil	Constant	w = 0004 =	
	Sta	ite	31. Date filed (Month, Day, Year)	32 Aegistrar	's Signature	CII KOAU	priver	shr.rud1	Md 20910	
	Regist	ar	JAN 05	2005 Blanc	's Signature					

			1 - State of Maryland / Department of Heal Certificate of Deal Certificate	ath	
	Physic /Medi		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year 20 A	M
	Examir	ner	St. Catherine's Nursing Center Emmitsburg	g Frederick	
	Funeral Director			Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Forei Country) 0ct. 21, 1912 Maryland	ign
	Maryland a-f ehow	tor	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limi 1 XX Yes 2 [] N	
	h with tha 23a or 28a	Funeral Director	10e. Street and Number 27 Main St. 21793	10g. Citizen of What Country? U.S.A.	
9036	permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "neturel", or items 23a or 28a-f ehow important: If item 27 is marked other than "neturel", or items 23a or 28a-f ehow yinjury or other traumatic event. I'm Medical Eraminar must be routified at ances.	þ	3 XWidowed 4 □ Divorced If Yes, Give 1 □ Yes 2 1 A No Sp	nic Origin? (Specify Yes or No- exican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White	
21215-0036	d within 72 h giene. er than "netu r the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+)	g most of working 16b. Kind of Business/Industry OWN home	
Maryland	ould be filed Mental Hygid arkad other atic event. It	To Be (17. Father's Name (First, Middle, Last) Harry Lowman	Mother's Name (First, Middle, Maiden Sumame) Pearl Haines	
	1 and 2 sho Health and I em 27 Is me		Joan Cox - niece P.O. Box 35, Ke	Number or Rural Route Number, City or Town, State, Zip Code) eymar, MD 21757	
Baltimore,	permit. Pagas I Department of H Important: If ite eny injury or ot once.		1 🕱 Burial 2 ☐ Cremation 3 ☐ Removal from State `4 ☐ Donation 5 ☐ Other (Specify) Cemetery, crematory or other place) Linganore Cemetery	1/4/2005 Unionville, MD	
Bal	Depar Depar Impor eny in		21. Signature of Funeral Service Licensee 22. Name and Address of Funeral Service Licensee 404 5. Main S 23a. Part1. Enter the disease, or complications that bened the death. Do not enter the mode of dying, such	St. Woodsboro, MD 21/98	
	Physician /Medical Examiner	iner	shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) a. Duy to (or as regnsequence of): Sequentially list conditions, if any, leading to immediate	ch as cardiac or respiratory arrest, Approximate Interval Between Onest and Death 2 yelow	? \
,0928	cate be executad physician and the burial-transit	dical Examin	Due to (or as a consequence of):	diovoscula Diseau 10 yr	1_
O. Box 6	ie death certifi the attending p hed for use as	Physician/Med	0	23d. Date of delivery Month Day Year	
rds, P	w requires that th baan signed by should be detacl	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in a	Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknow	٧n
al Records,		e Completed	es agricultural de la companya de la	24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings availab prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No	le
ion of Vital	ding Phys h. After this funeral dii	ToB	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4	Place of Death (Check only one) Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 2 No	
Division	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Diractor: completely filled in by the	Certification:		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospitel or At within 24 hours after of To the Funeral Dirac completely filled in by	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, da 2 Medical Praminer: On the basis of examination and/or investigation, in my opinion and manner stated.	n, death occurred at the time, date and place, and due to the cause(s)	
	CANAL SEE	~	· auall D18	29d. Date signed (Month, Day, Year)	
	4.4		Or Day Cod Mark D. Mark	ourg, MD 21727	
	Sta Regista		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		

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		_	1 - For Unpend Item 23	Sa, pt. 11,27,	28a-1 p	er me 6839 1-25-0 rtificate of Death			01235
	Physicia	an	1. Decedent's Name (First, Middle, Last)	W 4 - 1			2. Date of Deat Month	Dav Year	3. Time of Death
	/Medic	al	Nicole Dawn	Kielar		# 6't T 1 .: 4B	January		1:05 A M
	Examin	er	4a. Facility Name (If not institution, give s Potomac River near		on Bridge	4b. City, Town, or Location of Dea Oxon Hill	th	4c. County of Deat Prince Ge	
	Funeral Director		5. Social Security Number 6. Sex 1□	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		, 1975 Mi	hplace (State or Foreign buntry) chigan
	and w		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation			10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show rmust be routhed at	ō	Virginia Henrico		len Alle				1 Yes 2 No
	28a	rect	10e. Street and Number	61	ten Alle	10f. Zip Code	1	0g. Citizen of What Co	ountry?
	23a o	Funeral Director	10705 Mt. Ash Drive	2		23060		USA	
	ems	ner	11. Marital Status	2. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
336	be filed within 72 nours after death with the Marylan tal Hygiene. Ital Hygiene. Ital Hygiene. Ital Hygiene. Ital Hedical Examinat must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:	i	1 ☐ Yes 2 ☐ No Specify:	,	1	hite
Maryland 21215-0036	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Dece	dent's Usual Occupation	orkina	16b. Kind of Business/	/Industry
2	han "	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done during most of wo DO NOT use retired)			
7	filled w Hygier Sther th		17. Father's Name (First, Middle, Last)	5+	Flig	ht Paramedic	me (First, Middle, M	Life Evacu	ation
au	d be l	o Be	Michael Kielar			Marily		,	
<u> </u>	2 should be f and Mental h is marked of raumatic eve	Ě	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Maili	ng Address (Street and Number or Fi			Zip Code)
	12 t z		Michael Kielar/Fa			Lothian Road, Fa	airfax, V	a. 22031	
w	yes 1 a of Hea of item or othe		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ R		 Place of Disposered by Completery, createry 	matory or other place)		20c. Location - City or	Town, State
Ē	permit. Pages Department of I Important: ff its any injury or o		*4 ☐ Donation 5 ☐ Other (Specify)	Me		4		Alexandria	, Va.
g	permii Depar Impor any ir 2000		21. Signature of Funeral Service License	- 00	2	2. Name and Address of Facility Money & King Fu			
			23a. Part1. Enter the disease, or compli	cations that caused the d	eath. Do not en	171 W. Maple Average ter the mode of dying, such as cardia	e., Vienn ac or respiratory arre	a, Va. 221	Approximate
ı,	Physician		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.		ted by hypothermi			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a con:		ted by Hypotherms	La		
	Examiner		Sequentially list conditions						
	led Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con-	sequence of):				
	te be executed ysician and e burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a con	sequence of):				
		cai							
9	death certificate to attending physical for use as the k	Medi	IF FEMALE:					-	
ROX	ath ce ttendi or use	ian/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1☐Live birth 2☐F	etal death 3	Ectopic pregnancy		23d. Date of del Month	ivery Day Year
o.	The law requires that the death certifica tite has been signed by the attending phoage 2 should be detached for use as the	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time i 9☐ Unknown	of death 5L	Other (specify)			,
٠ <u>.</u>	that the hold by detail		Part II. Dther significant conditions cor	tributing to death but not	resulting in the u	inderlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
Vital Records,	w requires been sign should be	Completed by	Pelvic Injury				1 □ Y€	es 2 No 3 Pr	obably 4 Unknown
O O	aw re	piet					24a. Was ar		utopsy findings available completion of cause of
		Com					perform	ned? death?	
/ita	sician: The law certificate has l irector, page 2 s	Be	25. Was case referred to medical examiner?				eath (Check only on		
5	this ald	. To	Yes 2 No 27. Manner of Death	ospital: 1 Inpatient 2	2 ER/Outpatie			ence 6 Other (Spe	city) at scene
Division of	ding th. After funer	Certification:	1 □Natural 5 □ Pending 2 ■ Accident investigation	28a. Date of Injury (Month, Day Year 1-10-2005	11:10	Work?	Subject	injury occurred in	helicopter
NSI VISI	Atten or dea ector by the	ifica	3 Suicide 6 Could not be	28e. Place of Injury - A building, etc. (Sp	At home, farm, st.	P / /		reet and Number or Ru n, State) Woodro	ıral Route Number,
<u> </u>	urs afte oral Dir illed in			Potomac Ri	ver		bridge, C	xon Hill,	Maryland
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only 2 X Medical Examination)	ner: On the best of my ner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occurred.	e, and due to the ca curred at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	withii To tt	×	29b. Signature and title of certifier		2	29c. License number		9d. Date signed (Monta	
			laline	Clark A	y.	O.C.M.E.	J	anuary 11,	2005
			30. Name and address of person who co	mpleted cause of death (Print) 11 Penn Street,	Baltimore	, Marvland	21201
	Sta		31. Date filed (Month, Day, Year) JAN 2 0 2005	2. Registrar's Si				, ,	
	Registr	61	JM(7 & 11 /1)(5)	All allies a	h /has	LEFF II			

State of Maryland / Department of Health and Mental Hygien [] [] 5 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** January 6 2005 12:55 A^M Robert Martin Kibler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13623 Kibler Road Greensboro Caroline | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 29 10 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F 61 Yrs. 1943 Director 216-44-8052 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f ehow ir then "naturel", or items 23a or 28a-f ehov Tre Medical Exercites must be potified at 1 Yes 2 No Director Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21639 13623 Kibler Road U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. snt: If item 27 is marked other then "ury or other treumatic event, if a Ma. Elementary/Secondary (0-12) College (1-4or 5+) 12 equipment operator construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Martin Kibler Grace Warren Kibler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Sue Kibler/ wife 13623 Kibler Road Greensboro, Maryland 21639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ▼Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) permit. Page Depertment of Importent: If any injury or once. Greensboro Cemetery 01/08/2005 Greensboro, Maryland 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160 Greensboro, Maryland 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Netastatic Drostale carcinoma **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 0 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2. No 1 ☐ Yes 2 ☐ No Division of Vital ial or Attending Physicien: 1 s efter death. el Director: After this certifica ed in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 sesidence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide To the Hospital o within 24 hours eff To the Funerel DI completely filled in Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number

D 35 28 4 29d. Date signed (Month, Day, Year) 29b. Signature 1/7/05 who completed cause of death (Item 23a) (Type, Print)
Washington St Easton mo 2/60/ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 0 2005

Registrar

			For	State of Maryland				Mental Hygi	ene	F 01007
			State Registrar		Cen	tificate of L	Death		g. No. 4 U U	5 01237
П	Physicia	an 3	1. Decedent's Name (First, Middle, La					2. Date of Death Month	Day Yea	
risk.	/Medic		HOWARD KENNET 4a. Facility Name (If not institution, give			4b City Town or	Location of Death	JANUARY	9, 200 4c. County of Di	
	Examin	er	CLINTON NURSIN		татта		NTON			GEORGES
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. 8	Birthplece (State or Foreign Country)
	Director		233-42-7797	1X) M 2□F 77	Yrs.	Wortens Days	110013	JAN. 6,	1928 W	EST VIRGINI
	and w	}	Usuel Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	ation				10d. Inside City Limits
	Manylan -f show [ed st	Į į	ARYLAND PRINCE	GEORGES C	LINTO	N				1 ☐ Yes 2万No
	h the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	death with the Maryland ms 23a or 28a-f show Ludet be notified at		9211 STUART LA	NE		207	35		U.	S.A.
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	6. 13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puert	pecify Yes or No- Dican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	hours after tural', or ite	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes XXNo If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specify:	LILLEDD
5-003	2 hour	edt	15. Decedent's E	ducation	16a. Deced	ent's Usual Occup	ation	1	6b. Kind of Busine	WHITE ss/Industry
215	within 72 ene. then "net he Medic	plet	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give H life. D	aind of work done of O NOT use retired	during most of word	king		,
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2	should nd Men marke umatic	L C	GOLDEN KENNETH 19a. Informant's Name/Relationship (19h Mailine	Address /Street		D MARIE		a. Zio Codol
<u>8</u>	C1 00 .22 65		TERRY L. KIRK-							AD, MD20640
<u>6</u>	ges 1 and 21 tof Health If item 27 or other tri		20a. Method of Disposition		ace of Dispos	ition (Name of atory or other place			Oc. Location - City	
Ë	Pages nent of I int: If it		1 Donation 5 Other (Speci	Hemoval from State		URCH CE	1	3-05 A	CCOKEEK	,MARYLAND
Baltimore,	permit. Page Department Important: If any injury of once.		21. Signature of Funeral Service Lice	nsee M00479	22 R	Name and Addres	ss of Facility	SERVIC		
_	20E 2 9		Michael	O. Zgrun	\sim Γ	A PLATA	, MARYL	AND 20	646	
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that saused the death one cause on each line.	. Do not ente	r the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
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	cuted nd ransit	Examiner	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
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х 6	that the death certificated by the attending properties as	/Me	IF FEMALE:	23c. If yes, outcome of pregnar	ncv	=0.0			23d. Date of	delivery
Вох	death atten	clar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			Month	Day Year
o.	t lhe c by the achec	Physiclan/Me	9 Unknown	9□ Unknown						
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ord	w requir been si should I	ted				-		1 Te	s 2 Mo 3 □	Probably 4 Unknown
Vital Records,	e law has by je 2 st	Completed						24a. Was an autopsy	prior	autopsy findings available to completion of cause of
ᆵ								perform 1 ☐ Yes 2	death No 1 1 Y	es 2 No
Ž		o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	EB/Outpaties	Oth	ar /	th (Check only one		
ō	y Phys er this eral di	n: To	27. Manper of Death	28a. Date of Injury	ER/Outpatient 28b. Time of	28c. Injun Work	100	ome 5 Resider 28d. Describe hor		pecify)
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Division of	r Atte	Certification:	3 Suicide 6 Could not to determined		me, farm, stre	et, factory, office		28f. Location (Str. City or Town		Rural Route Number,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my know miner: On the basis of examinat and manner stated.	wledge, death ion and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner ite and place, and o	as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. Licens	e number	29	d. Date signed (Me	onth, Day, Year)
}	- >- 0	1	Andres V	stres MD		05	1051	1	annary	10. 2.005
	2		30. Name and address of person who	completed cause of death (Item	23a) (Type, I	Print)	W 72.07	K. 31 HB 104	, w. w. w. /	10, 2005
			Andres Salas	ar 3621	L1901	r Rd, Ul	leett -	it, MD	2104	7
	Sta Regist		31. Date filed (Month, Day, Year)	32, Registrar's Signat	ture O	2060				
			notes the first	Sand Brown and	Salar Salar					

State Registrar NOMAN

THANWY 31. Date filed (Month, Day, Year) 32 Registrar's Signature JAN 0 6 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

300

AURURA

STREET

CAMBRIDGE MAD

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 2005 ea 5:10 p.m. Bettie Mae LEIS January 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) Washington Hagerstown 640 Cornell Avenue If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) Months Days Hours 1□M 2XF 84 Yrs 579-22-6275 Sept. 11,1920 Missouri Usuel Residence of Decedent 10d. Inside City Limits 10a. Stete 10c. City, Town or Location 1 ☐ Yes 2X No Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number USA 21742 640 Cornell Avenue 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No Specify: white 3 X Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) government secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Mae Nunn Charles Jones 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 636 Cornell Avenue, Hagerstown, Md. 21742 Kathy Leis - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/5/05 Hagerstown, Maryland Hagerstown Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22/Name and Address of Facility MINNICH FUNERAL HOME E. Wilson Blvd., Hagerstown, Md. 21740, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final diseese or condition resulting in death) Chkrun ISCHEMIC CARDIOMUPATH Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examinar

Depentment of h Important: If ite any injury or off

Physician

/Medical

Examiner

Funeral Director

Completed by

Be

Funeral

Director

Pagas 1 end 2 should be filed within 72 hours eftar deeth with the Maryland

Baltimore, Maryland 21215-0020

if Heelth and Mantal Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-1 show other treumstic event, the Madical Examiner must be notified at

To the Hospital or Attending Physician: The law raquiras that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician end completely filled in by the funerel director, page 2 should be datached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

Be Completed by

edical Certification: To

1 ☐ Yes 2 No 27. Manner of Death Natural 2 Accident 3 ☐ Suicide

31. Date filed Month

29a. Certifier (Check only

4 ☐ Homicide

5 Pending investigetion 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury et Work?

2 🗆 No 1 Yes 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier

2005

29c. License number

29d. Date signed (Month, Day, Year)

Medical Campus Rd., Hegerstrum MD of deeth (Item 23e) (Type, Print) 30 Name Ella

32. Registrer's Signeture

State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** ALEXANDER N/M/N LEWYCKYJ JANUARY 12,2005 1:20 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES WALDORF WALDORF HEALTH CARE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1X)M 2□ F Yrs. FEB.28,1917 UKRAINE Director 174-26-6803 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ns 23a or 28e-f shormers to a continue at WALDORF 1 ☐ Yes 2 No CHARLES MARYLAND Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 4140 OLD WASHINGTON ROAD 20602 by Funeral 1 and 2 should be filed within 72 hours after death n *netural", or items ? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 YNo
If Yes, Give
Year or Dates: Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes XXNo Specify: 3€Widowed 4 □ Divorced Specify: WHITE Completed 7 is marked other then "netur treumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ ELECTRICIAN MANUFACTURING 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental JULIAN LEWYCKYJ OLGA DOBRJANSKYJ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2009 ST. THOMAS DR., APT. 305, WALDORF, MD20602 JULES LEWYCKYJ -SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 tment of I XIXBurial 2 ☐ Cremation 3 ☐ Removal from State 6 Department of Important: if any Injury or once. 1-17-05 ABINGTON, PA ST.MARY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) M00479 22. Name and Address of Facility KAYMOND FUNEŘAL SERVICE, PA20646 LA PLATA, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physiclan/Medical Due to (or as a consequence of) attending ph for use as t ed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 1 Yes 2 40 3 Probably 4 Unknown ģ ate has been signi page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed certificate has 20 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) 2 No ဥ To the Hospital or Attending Physi within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral dir 1 ☐ Yes After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 12/2005 D5228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 NALIN MATHUR, M.D. 10 ST.PATRICKS DR., STE. 404, WALDORF, MD 20603

State Registrar

31. Date filed (Month, Day, Year)

9

2005

32 Aegistrar's Signature

DHMH 16 Rev 6/95

Maryland 21215-0020

altimore,

Division of Vital Records, P.O. Box 68760

			1 - For State of I	Maryland / Depa <i>Cei</i>	artment of H			giene leg. No. 2005	01241
	Physici /Medio		Decedent's Name (First, Middle, Last) Isabelle NMN				2. Date of Dea Month	Day Year	5 07:16 KM
	Examin	ėr	4a. Facility Name (If not institution, give street and numb Washington County Hospita		4b. City, Town, or Hagersto		tn •	4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthday)	If Under 1 Year Months Days				nthplace (State or Foreign country) ryland
l.	Director		214-28-5280 1 M 2MF Usual Residence of Decedent	74 Yrs.			May 22,	1930 Ma	ryland
	yland how		10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	8a-fs	Director	Maryland Washington	Hagersto					1 Yes 2X No
	with to		10e. Street and Number 18807 Eliason Way		10f. Zip Code 21	742	1	10g. Citizen of What C U.S.A.	ountry?
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show aumatic event, the Madical Examirant rust be instiffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 XWidowed 4 Divorced 1 2. Was Decede Armed Force 1 Yes 2 If Yes, Give	X No I	Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 ☑ No		Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	ite, etc.
9	2 hour	ted t	15. Decedent's Education	16a, Decec	lent's Usual Occupa	ation		16b. Kind of Business	s/Industry
215	ithin 7. le. len "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	or 5+)	kind of work done a DO NOT use retired,	luring most of wo	orking		
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nor	Pages nent of H int: If Ite		1228Burial 2 □ Cremation 3 □ Removal from Sta 4 □ Donation 5 □ Other (Specify)	comotoni cron	natory or other place		an. 10.	•	ng, Maryland
Baltimore,	permit. Page Department Important: If any njury or once.		21. Signature of Funeral Service Licensee	22	. Name and Addres	s of Facility	Minnich 1	Funeral Ho	-
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54	1-7		30. Name and address of person who completed cause Ciccarell	of death (Item 23a) (Type,	Print) MO	e Will	ampa	4 MD 2	1795
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/Medi		Victor Lynn MAR					1	5	05	8.30a M
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yland		10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation				1	0d. Inside City Limits
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th with th	Funeral Director	10e. Street and Number 13 Berner Avenue			10f. Zip	Code 21740		,	zen of What Cour USA	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if item 27 is marked other then "naturel", or iteme 23a or 28e-f ehow Importent: if item 27 is marked other the "naturel", or iteme 23a or 28e-f ehow purge.	by Funer	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give			ent of Hispanic Origin fy Cuban, Mexican, P	? (Specify Yes or N uerto Rican, etc.)	0-	14. Race - Americ Black, White, Specify: Wh	
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2 sho and h is ma	ľ	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address	(Street and Number o	r Rural Route Numi	ber, City or	r Town, State, Zip	Code)
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Physician / Medical Examiner the private per executed by the private	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect. Due to (or as a consect.) Due to (or as a consect.)	wanda of):	UL	AP-DIO VASC	ULAR D	Ha.	se.	rgins.
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	aldeath 3[□Ectopic pre □ Other (s <i>p</i> e			2	23d. Date of delive Month	ery Day Year
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		30. Name and address of person who	completed se of death (Iter	n 23a) (Type,	Print)					
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			1 - For State Registrar	State	of Maryland		artment of I		d Mental Hy	giene	5 01243
			Negistrar Decedent's Name (First, Middle	, Last)			rumouto or		2. Date of De		3. Time of Death
ı	Physicia		Sandra	Lee	Murray				Januar	v 10, 200	M
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	or Location of E		4c. County of E	
			St. Mary's	Nursing (Center			Leonard	ltown	St. N	Mary's
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. Ia			If Under 24			Birthplace (State or Foreign Country)
	Director		212-62-0773	1 M 2 F	57	Yrs.			June 21	, 1947 V	irginia
	and w #	}	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or L	ocation				10d. Inside City Limits
	Mary	ō	Many land Ct	M1-		7	Leonardto				1 ☐ Yes 2 ■ No
	the 28e	Director	Maryland St. 10e. Street and Number	Mary's			10f. Zip Code	M11		10g. Citizen of What	Country?
	72 hours after death with the Maryland 'natural', or items 23s or 28e-f show dical Examinar must be notified at	Ö	40560 Junio	re Court				20650		United S	tatac
	death ms 2	Funerai	11. Marital Status	12. Was De	cedent Ever in U.S	S. 13.	Was Decedent of I		? (Specify Yes or No Puerto Rican, etc.)		merican Indian,
9	after or ite		1 ☐ Never Married 2 ☐ Marri	Armed F ied 1 ☐ Yes If Yes, G	2 No		1 ☐ Yes 2 ■ No		ruerto Fican, etc.)	Specify: W	/hite, etc.
8	ours iral',	d b	3 Widowed 4 Divorced	Year or	Dates:		10 163 2010	ороспу.		Specily. W	
2	"natu	Completed by	15. Decedent (Specify only highes)	(Give	dent's Usual Occup kind of work done	during most of	f working	16b. Kind of Busine	ess/Industry
12	withir ane. than	dm	Elementary/Secondary (0-12)	College	(1-4or 5+)	me.	DO NOT use retire	•		Dianh	1.1
d 2	filed Hygie ther		12. Tather's Name (First, Middle, I	Last)			DISABLEO	7	Name (First, Middle,	Disab Maiden Surname)	rea
an	ld be ental ked o	To Be	William Cai	n					Imogene R	amev	
ary	shou nd M mar	-	19a. Informant's Name/Relationsh			19b. Mail	ing Address (Street	and Number o	or Rural Route Number		e, Zip Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, Ite Medical Experient must be notified at once.		Lisa M. Walter	/ Dau	ghter	40560) Juniors	Court,	Leonardt	own, Marv	Land 20650
ore.	of He of He item		20a. Method of Disposition 1 □ Burial 2 ■ Cremation	2 Demousl from	ne	ace of Disp	osition (Name of matory or other pla		Date	20c. Location - City	
Ĕ	Pag ment ant: I		'4 □Donation 5 □Other (Sp		Brin	nsfiel	ld-Echols	Cr. 1-	-14-2005	Charlotte	Hall, MD
alt	Departi Departi Importi any inj		21. Signature of Funeral Service	icensee	011	2	2. Name and Addre	ess of Facility	Brinsfiel	d Funeral	Home, P.A.
ш	20 E 2 9		David A. Go	1-11							1D 20650-0279
т			23a, Part1. Enter the disease, or shock, or heart failure. List	complications hat only one care e on			_	_	rdiac or respiratory as		Approximate Interval Between _Opset and Death
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	_a. ADV	ANCED	ML	ZHEINIE	KS 1	EMENTI	9	YEARS
6	/Medical Examiner		resulting in death)	Due to	o (or as a consequ	ence of):					
	SEC.	e.	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a consequ	ence of):					
	uted d ansit	Examiner	cause. Enter Underlying that initiated events								
o	an an rial-tr		resulting in death) Last	Due to	o (or as a consequ	ence of):					
8760,	death certificate be executed e attending physician and id for use as the burial-transit	lical		d							
Ø	e as t	Physician/Med	IF FEMALE:								
Вох	eath certifi attending for use as	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome of pregnar birth 2 ☐ Fetal	death 3	Ectopic pregnanc	y		23d. Date of Month	delivery Day Year
		ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟Preg 9□Unk	gnant at time of de nown	ath 5	Other (specify) _				
P.0	res that the d igned by the be detached		Part II. Other significant condition	ns contributing to	death but not resu	ilting in the i	underlying cause gi	ven in Part I.	23e. Did to	obacco use contribut	e to the cause of death?
of Vital/Records,	faw requires that the as been signed by th 2 should be detache	d by	/AST	HMA					101	Yes 2□No 3□	Probably 4 Onknown
000	sw require s been si	Completed							24a. Was	an 24b. Were	autopsy findings available
/R	9 L 0	E							— autop perfo 1 □ Yes	osy prior death	to completion of cause of 1? /es 2 No
ita	ysician: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?					26. Place of	Death (Check only o		
<u></u>	S S	10	1 Yes 2 D No			ER/Outpatie	nt 3□ DOA Ot	her: 4i Nursi	ng Home 5 ☐ Resid	dence 6 🗆 Other (5	Specify)
	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☐ Matural 5 ☐ Pendin	g 28a. Date (Mo	e of Injury onth, Day Year)	28b. Time of Injury	Wo			now injury occurred	
Sio	Attending r death. ector: After	cati	2 Accident investig 3 Suicide 6 Could r	not be	an of lower At he			Yes 2 □No	_	Street and Number o	r Rural Route Number,
Division	2552	Certification;	4 ☐ Homicide determ		ding, etc. (Specify		reet, factory, office		City or Tov	vn, State)	nurai noute Nurriber,
_	To the Hospital or Attenwithin 24 hours after deat within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier Certifyin	g Physician: To th	ne best of my know	wledge, dea	th occurred at the ti	me, date and p	place, and due to the	cause(s) and manne	r as stated.
	n 24 }	edical	(Check only 2 Medical one)	Examiner: On the	basis of examinat inner stated.	ion and/or in	nvestigation, in my	opinion, death	occurred at the time,	date and place, and	due to the cause(s)
	To the To the comp	M	29b. Signature and title of certifier	1		AIN	29c. Licen			29d. Date signed (M	
)	W		1) Kerl	L		MD	D^{\perp}	56096	2	1-13-0	4
	Ty		30. Name and address of person	who completed car	use of death (Item	23a) (Type	S, TIME	E NOTO	HRD HO	LLYNDOD	MD 20636
	Sta Registr		31. Date filed (Month, Day,	7 2005 32	egistrar's Signat	4	or the				

		-	For State Registrar	State of M	laryland / Depa	artment of F			giene Reg. No. 2005	01244
	Physicia	ın	Decedent's Name (First, Midd Alice		ning			2. Date of Dea	Day Year	3. Time of Death 4:05 P M
	/Medic Examin	200	4a. Facility Name (If not institution			4b. City, Town, o	or Location of Death	January	4c. County of Death	
1	LAAIIIII	ÇI S	Ft. Washingto				shington		Prince Geo	rge's
	Funeral Director		5. Social Security Number 248–56–5254	6. Sex 7. A 1 ☐ M 2 🔀 F	ge (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da July 1	9. Birth Cou 4, 1935 Sout	place (State or Foreign ntry) ch Carolina
	pu *		Usual Residence of Decedent 10a. State 10b. Count	,	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryla f sho	jo		e George's		hington				¥ Yes 2 No
	or 28a	irec	10e. Street and Number			10f. Zîp Code			10g. Citizen of What Cou	ntry?
	ath will	raiD	9005 Hewlett				20744		U.S.A.	
9800	be filed within 72 hours after death with the Maryland Hygliene. Hygliene dither than "naturel", or Items 23s or 28s-f show adolfred the Marileal Examitation usat to modified all event, the Marileal Examitation usat to modified all	d by Funeral Director	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divorce	d If Yes, Give Year or Dates]No	1 ☐ Yes 2x No		ecify Yes or No- Rican, etc.)	Specify: BL	, etc. ACK
Maryland 21215-0036	within 72 h ene. than "nate	Completed by	(Specify only high	nt's Education est grade completed) College (1-40)	(Give life.	DO NOT use retired	during most of work	ring	16b. Kind of Business/Ir	ndustry
121	filed w Hygier ther th		Unknown 17. Father's Name (First, Middle	. Last)	Dry	Cleaners	18. Mother's Nam	e (First, Middle,	Private Maiden Sumame)	
/lan	12 should be filed within n and Mental Hygiene. I's marked other than " raumatic event, the Me.	To Be		anning			Viola		Manning	
Man	5 = 2 =		19a. Informant's Name/Relation Alice D. Willi.			-			er, City or Town, State, Zi omery Ala.	
Baltimore,		- Statement of the	20a. Method of Disposition 1	3 □Removal from Stat	20b. Place of Disponentery, cre			Date 1	20c. Location - City or T	
Itim	permit. Page Department of Important: If any injury or once.		' 4 ☐ Donation 5 ☐ Other (21. Signature of Funeral Service				ntery 1/6	1:	Brentwood, M INS FUNERAL	11 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2
Ba	Department Department Important in any is		X.D. M	aushall	·				er, Maryland	
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cause t only one cause on each	ed the death. Do not en line.	ter the mode of dyir	ng, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Emphy a.						Onset and Death
	Examiner			Due to (or a	is a consequence of):					
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequence of):					
,	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):					
8760,	cate be ohysicia the bur	cal								
Box 68	eath certific attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		2 Fetal death 3	□Ectopic pregnancy	у		23d. Date of deliv	rery Day Year
P.O.	that the de ed by the detached	hysi	9 🗆 Unknown	9□ Unknown						
	signed by	þ	Part II. Other significant condit Pulmonary	_	but not resulting in the t	underlying cause giv	ven in Part I.		obacco use contribute to l Yes 2□No 3□Pro	the cause of death? bably 4 Unknown
Records,	aw requires been size should	Completed						24a. Was	an 24b. Were aut	opsy findings available
I Re		Com						autop perfo 1 ☐ Yes	rmed? death?	ompletion of cause of 2 X No
Vital	Physicien: The this certificate ral director, page	Be	25. Was case referred to medic examiner?	Hospital:		Ct	26. Place of Deal	and the second of the last		
of	Phys r this ral dii	- To	1 ☐ Yes 2 X No 27. Manner of Death	1 ∐ Inpa 28a. Date of In	ijury 28b. Time o	III JU DOX			dence 6 Other (Speci how injury occurred	fy)
ion	Attending Ph r death. ector: After th by the funeral	atlor	1 XNatural 5 ☐ Pend 2 ☐ Accident inves	ing (Month, L tigation	Day Year) Injury		rk?]Yes 2□No			
Division	I or Attendate death Director:	Certification:	3 ☐ Suicide 6 ☐ Couk 4 ☐ Homicide deter	mined 286. Place of I	njury - At home, farm, st etc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tox	Street and Number or Rur vn, State)	al Route Number,
	To the Hospital or Attenwithin 24 hours after deati To the Funerel Director: completely filled in by the	edical		ing Physician: To the bes I Examiner: On the basis and manner	of examination and/or in	nvestigation, in my o	opinion, death occur	red at the time,	date and place, and due t	to the cause(s)
	To t To t	×	29b. Signature and title of eartif	er		29c. Licens	6093		29d. Date signed (<i>Month</i> ,	Day, Year)
P		Î	30. Name and address of perso			, Print)		ıbelt. M	laryland 207	70
	Sta Registi		31. Date filed (Month, Day, Yea JAN 0 7	r) 22. Regis	strar's Signature			,		
			JANOI	- Company	I THE MICH					

Piease Type or Print in Black Indelible Ink. Assure Ali Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Y January 6, 2005 **Physician** Ida D. Mvers 1:45 A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Manor Care Potomac Montgomery Nursing Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 05/15/1916 9. Birthplace (State or Foreign Country) Kentucky 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2/CXF 88 578-30-6739 Yrs Director Usual Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter deeth with the Meryland Depertment of Health end Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, its Medical Examinal must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Charles White Plains Be Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3705 Foxhall Place 20695 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes ŽIXI No 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes X X No Specify 3 ₩idowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government Key Punch Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pauline Weinberg Alexander Dessoff 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3705 Foxhall Place White Plains, Maryland 20695 Lynda Willett / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Wash. Nat. Cemetery 01/13/2005 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Juneral Service Licensee 22. Name and Address of Facility. George P. Kalas Funeral Home P.A. ala 6160 Oxon Hill Road Oxon Hill, Marvland 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examina Physician/Medical Examiner ettending physician end for use es the buriel-trensit or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? sete has been signed by the page 2 should be deteched 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Yes XXXINO 1 ☐ Yes 2 ☐ No this certificete 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: XX Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 Yes 2XXVo 1 Inpatient 2 ER/Outpatient 3 DOA s efter death.

it Director: After this ed in by the funerel d 28c. Injury at Work? 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Injury XX Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled in XIX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie leted cause of death (Item 23a) (Type, Print) WEDMONSTON DR, ROCKVILLE, MI) 30. Name and address of person w

DHMH 16 Rsv 6/95

State Registrar

31. Date filed (Month, Day, Year)

JAN 0 7 2005

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82. Registrar's Signature

		State o	Co	artment of Health and N rtificate of Death	Reg.	/11115	0124
Physici /Medic Examin	al er	1. Decedent's Name (First, Middle, Last) Jewell Ann Mack 4a. Fecility Name (If not institution, give street and nut Control of the contro		4b. City, Town, or Location of Death	1	2005 4c. County of Death	
Funeral Director		Bradford Oaks Nursing 5. Social Security Number 5.79-42-6115 Usual Residence of Decedent	T HOME 7. Age (In yrs. last birthday) 72 Yrs.	Baltimore Cli If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		Prince Ge 9. Birth Con Geo.	place (State or Fore
the Maryland 28a-f show	ector	10a. State 10b. County PG Md 10e. Street and Number	10c. City, Town or Lo Suitland	10f. Zip Code	100	. Citizen of What Cou	10d. Inside City Lim 1 X Yes 2 □
nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ariment of Health and Mental Hygiene. ortent: if Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic.	Completed by Funeral Director	3940 Bexley Place #80 11. Marital Status 1 Never Married 2 Married 1 1948	edent Ever in U.S. 13. orces?	20742 Was Decedent of Hispanic Origin? (Stiff Yes, specify Cuban, Mexican, Puerto		USA 14. Race - Amer Black, White	ican Indian,
within 72 hours a ene. than "natural", o ha Medical Exan	pieted by	3√ Widowed 4 □ Divorced If Yes, Gir Year or D 15. Decedent's Education (Specify only highest grade completed)	re ates:	1 ☐ Yes 2 Å No Specify: dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king 161	Specify: Bla b. Kind of Business/In	
ould be filed wilt Mental Hygiene arked other tha atic event, tha	To Be Com	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Thomas Starks			ne (First, Middle, Mai a Starks	Fed. Gov.	•
1 and 2 shou Health and M em 27 Is mar ther traumat	L	19a. Informant's Name/Relationship (Type, Print) Deborah Bracey (Dau 20a. Method of Disposition	ghter 1011	ng Address (Street and Number or Ru Jubilee Way, W osition (Name of	aldorf M		
permit. Pages Department of t Important: If Its any injury or of once.		1 X Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Washing	osition (Name of matory or other place) ton Nat.Cem1/8/ 2. Name and Address of Facility Tr	2005 Su	itland,	Md.
Physician /Medical Examiner	Examiner	Sequentially list conditions.					Approximate Interval Between Onset and Doath
rificate be executed og physician and as the burial-transit	Ical	that initiated events c	(or as a consequence of):				
ne death cer the attendir hed for use	Physician/Med	23b. was decedent pregnant 1 Live t	nant at time of death 5[□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	very Day Year
The law requires that it tte has been signed by sage 2 should be detac	by	Part II. Other significant conditions contributing to d	eath but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac	2 No 3 Pro	
(G) -4-	e Completed	25. Was case referred to medical		26. Place of Dea	24a. Was an autopsy performed 1 Yes 2)C	prior to co	opsy findings availa ompletion of cause of 2 No
ding Phys	Certification: To B	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Inpatient 2 ☐ ER/Outpatie of Injury th, Day Year) 28b. Time of Injury	nt 3 DOA Other: Wursing H	ome 5 Residenc 28d. Describe how	injury occurred	
To the Hospital or Attenwithin 24 hours after death To the Funeral Director:		4 Homicide determined 209. Place build 299. Certifier 1 Certifying Physician: To the		th occurred at the time, date and place	City or Town, S	se(s) and manner as	stated.
To the Ho within 24 h	Medical	(Check only 2 Medical Examiner: On the band man 29b. Signature and title of certified	asis of examination and/or in ner stated.	vestigation, in my opinion, death occu		Date signed (Month,	
(3) Sta		31. Date filed (Month, Day, Year)	se of death (Item 23a) (Type,	Print) Prov 15#10	of Fr. W.	Thing Ku	100.20
Regist		JAN 0 6 2005	w 1 Apres				

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ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [] [] 5 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3, 2005 4:45 PM January Moore Agnes /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery National Lutheran Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1□M 2∰F Months Days 376-54-9519 98 Yrs. June 19,1906 Wisconsin Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f ahow ed other than "neturel", or Items 23s or 28s-f ahov event, the Medical Exercine must be notified at Md. 1 X Yes 2 ☐ No Montgomery Rockville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9701- Veirs Drive 20850 USA Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: δ 3 Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Importent: If item 27 is marked other th any injury or other traumatic event, I'ms once. Teacher Education 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Joseph Hoschek Anna Mikula 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 20508-Bargene Way, Germantown, Md. 20874 Charlotte Rogers-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Crematory-1/5/05-Alexandria, Va. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hysong Co., Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. DC shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final disease or condition resulting in death) meumone odA45 Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and is the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 hed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this After this funeral c 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Leath Certification; 1 Natural 5 Pending s after dec. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funerel I ECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D500612 JAMUANY 3,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lutheran Home National mo SAMUFL 6 MALLER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 6 2005 Registrar

			1 - For State Registrar	State of M	laryland / De	partment o e <i>rtificate d</i>			giene,		5 01248
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	/Medio		4a. Facility Name (If not institution, g.			4b. City, Tow	n, or Location of De	Januar		2005 County of De	
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	Funeral			Sex 7. A	ge (In yrs. last birthda		ar If Under 24 F	Irs. 8. Date of Bir In. (Month, Da	th y, Year)		irthplace (State or Foreign Country)
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	yland		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
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	death with the Maryland ms 23a or 28a-f show Linust be rediffed at	Funerai	12136 Veirs Mi	12. Was Deceden	t Ever in U.S. 1:	209 3 Was Decedent		(Specify Yes or No		US 14 Bace : An	A nerican Indian,
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<u>a</u> u	id be ental ked o ic eve	To Be	George W. Mull:					ly Ison	, maiden	30mame)	
Maryland 21215-0036	shou and M s mar	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	iling Address (Str	eet and Number or	Rural Route Numb	er, City or	Town, State	, Zip Code)
2	and 2 ealth a m 27 Is			ns/ Son				nue, Reho	both,	, DE 1	9971
Baltimore,	Pages 1 nent of Ha mit: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State	20b. Place of Dis	position (Name or rematory or other	^{place)} Ja	nuary 4	20c. Lo	cation - City o	or Town, State
<u>=</u>	rtment:		* 4 ☐ Donation 5 ☐ Other (Special Service) Lice		Metropol			005	Alex	andria	, Virginia
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic expects.		> Epli f	Junes				s Funeral		e Inc. Spring	, MD 20901
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8760,	icate be executed physician and s the burial-transit	dicai Exa	resulting in death) Last	•	s a consequence of): Bowel Obst	ruction					12/24/04
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ds, P	uires that signed b	by	Part II. Other significant conditions Coronary Artery		but not resulting in the	underlying cause	given in Part I.		obacco us		to the cause of death? Probably 4 JUnknown
Records,	The law requirate has been page 2 should	Completed						24a. Was autor perio		prior to death?	autopsy findings available completion of cause of
		O	25. Was case referred to medical				26. Place of D	1 ☐ Yes Death Check onl		1 □ Ye	s 2 No
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Division of	or Attending Physician: Iter death. Director: After this certific in by the funeral director,		27. Manner of Death 1 ♣ Natural 5 ☐ Pending 2 ☐ Accident investigate		ury 28b. Time ay Year) lnjury	of 28c. I	njury at Vork? Yes 2 No	28d. Describe			
N N	tal or Attend s after death al Diractor: , ad in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	286. Place of in	njury - At home, farm, tc. (Specify)	street, factory, offi	ce	28f. Location (City or Tox		Number or F	Rural Route Number,
	To the Hospital o within 24 hours aft To the Funeral Di completely filled in	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	hysician: To the besi miner: On the basis and manner s	t of my knowledge, de of examination and/or tated.	ath occurred at the investigation, in m	time, date and pla by opinion, death of	ace, and due to the courred at the time,	cause(s) a date and	and manner a place, and du	as stated. re to the cause(s)
		W	29b. Signature and title of certifier	ut			ense number 0233				nth, Day, Year) , 2005
	01,		30. Name and address of person who	completed cause of	death (Item 23a) (Typ	e, Print)					
			Nan Wang, M.D. 31. Date filed (Month, Day, Year)		necticut A		ensingtor	n, Md 208	95		
: <	Sta Registr		JAN 05	2005	trar's Signature	porte					

ORIGINAL

Frank Greg Morrell 05-00032 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death

a	
Physician	
/Medical	
Examiner	

	Physic /Medi		Frank	Gregory		Morrel	1		Januar		2005 ^{Year}	12:27 A
	Examir	er	4a. Facility Name (If not institution 5811 Hobblebus)	n, give street and number) n Court			4b. City, Town, o Frederic		of Death		ounty of Death ederick	
	Funeral Director		5. Social Security Number 220-88-6970 Usual Residence of Decedent	6. Sex 7. Ag 1 M 2 □ F	e (In yrs. Ia 42	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of B Min. (Month, D April 2	irth a <i>y, Year)</i> 20,196	9. Birth Cou 2 Ohio	iplace (State or Fore intry) O
	aryland show		10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Lim
	with the Maryland a or 28a-f show Les notified at	ţċ	Maryland Fr	ederick		Fre	ederick				İ	1 √ Yes 2 □
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cou	intry?
	death w		5811 Hobblebus				2170				ted St	ates
	er de Items	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces?		13.	Was Decedent of H f Yes, specify Cuba	lispanic On an, Mexicar	igin? (Specify Yes or N n, Puerto Rican, etc.)	0- 14	Race - Ameri Black, White	
21215-0036	hours after tural', or Ite	ğ	3 ☐ Widowed 4 ☐ Divorced	Wyor Chin	NO .		I□Yes aZNo	Specify:		Sį	pecify: Wh	nite
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an	sho and h is ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailin	g Address (Street	and Numbe	er or Rural Route Numb	per, City or T	own, State, Zij	p Code)
	ss 1 and 2 should of Health and Mer i item 27 Is marke r other traumetic		Frank J. Morrel	1/ Father					1-A./ Fred	lerick	, MD 2	21701
Ore	ges 1 It of H If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 Removal from State			sition (Name of natory or other plac		Date		tion - City or T	
Baltimore,	permit. Pa Departmen Importent: any injury		4 □ Donation 5 □ Other (S21. Signature of Funeral Service		Fre	dericl	k Cremato	ry ¦C	01/04/2005	Frede	erick,M	aryland
Bal	permit. Pages Department of H Importent: If its any injury or of		21. Signature of Funeral Service	Licenape	/	/ 22	. Name and Addres	ss of Facilit	y Stauffer	Funera	al Home	s, P.A.
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	ne Hosp ne Fune sletely f	Medical	29a. Certifier (Check only one)	g Physician: To the best of Examiner: On the basis of and manner sta	examinatio	edge, death in and/or inv	occurred at the time estigation, in my op-	ne, date an pinion, deal	d place, and due to the th occurred at the time,	date and pla	d manner as s ace, and due to	tated. the cause(s)
	To the transfer of the transfe	ž	29b. Signature and title of certifier		00		29c. License			29d. Date s	igned (Month,	Day, Year)
•	7		tatu 1	roni-10	lle	S	O.C.M.			Januar	y 2, 2	005
	4)		30. Name and address of person	who completed cause of the	eath (Item 2	11 Per	nn Street	, Bal	timore, Ma	ryland	l 21201	
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State Registrar

	1		1 - State of Maryland /	Department of Health an Certificate of Death		ene 005 01251
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	MILLER	2. Date of Death Month JANUAL	Day Year
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١.	Director		218 34 1184 1⊠M 2□F 67 Usual Residence of Decedent 10a. State 10b. County 10c. City, To	Yrs. Months Days Hours	May 6,	1937 Maryland
	r 28a-f show	Director	Maryland Cecil North 10e. Street and Number		10	1 X Yes 2 □ No
0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Id other then "naturel", or Items 23s or 28s-f show event, the Medical Ever it at most be notified at	by Funeral	203 Mauldin Avenue 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	21901 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, 1 Yes 2 No Specify:	n? (Specify Yes or No-	nited States 14. Race - American Indian, Black, White, etc. Specify: white
Maryland 21215-0036	d within 72 h pene. r than "natu the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) Stodian	of working	6b. Kind of Business/Industry oard of Education
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Ma	ges 1 and 2 should t of Heatth and Mer if item 27 is marke or other treumatic			b. Mailing Address (Street and Number 03 Mauldin Avenue,		
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Baltimore,	ment of lent; if its		4 Eponation 3 Circle (Specify)	ery crematory or other place) East Methodist Ja Cemetery	nuary 8, No 2005	rth East,Maryland
Ball	permit. Pag Depertment Importent: f any injury o		21. Signature of Fuperal Septice Libertee	22. Name and Address of Facility 127 South Main S	Crouch Fun treet,North	eral Home East,Maryland 21901
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Division of	Attending Physrdeath. ector: After this by the funeral di	atlon; To	1 Inpatient 2 ER/O	utpatient 3 DOA Other: 4 Nursi Time of 28c. Injury at Work? 1 Yes 2 No	ing Home 5 Residen 28d. Describe how	
Divis	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, the building, etc. (Specity)	arm, street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
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	To th within To th compi	Me	29b. Signature and title of certifie	29c. License number		d. Date signed (Month, Day, Year)
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	2		30. Name and address of person who completed cause of death (Item 23a) KENT NILSON 600 North Wolfe St. 31. Date filed (Month Day Yaar)	rect BALTIMORE,	MARYLAN	MUARY S, 2005
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	er de Item	une	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No to Rican, etc.)	- 14. Race - Am Black, Whi	
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Maryland	us 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Modical Everther must be rectified at	-	19a. Informant's Name/Relationship (19b. Maili	ng Address (Street			er, City or Town, State,	Zip Code)
	and 2		Rhonda E. Sarv	er/Aunt	1174	4 S. Dul	ont Hwy	y., Smy	rna, DE	19977
ore	of He		20a. Method of Disposition	Demonstra	20b. Place of Dispo cemetery, cree	sition (Name of matory or other pla-	ce)	Date	20c. Location - City or	Town, State
<u>Ĕ</u>	Pag nent ant: if		1 ☐ Burial 2 ∰ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	()	R.A. Fer	ris & (200 Zoni	uary /	West Che	ester.PA
Baltimore,	permit. Pages Department of I Important: if Ite any injury or of once.		21. Signature of Fundral Service Licer			2. Name and Addre	ss of Facility			COUCTYTA
m	80 = 8		XXIII	/		Andrew 250 Fac	G. Gee	runera	I Home	21021
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	olications that caused th	e death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	21921 Approximate Interval Between
	Frysician		tmmediate Cause (Final disease or condition	Hungi	na					Onset and Death Lmm odie fe
4	/Medical		resulting in death)	Due to (or as a c	consequence of):					- mm = 2, 6/2
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10	ם ב	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	onsequence of):					
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760,	ate be executed nysician and he burial-transit	<u> </u>	rossiting in doubly cast	Due to (or as a c	consequence of):					
687	cate b	dicai		d						
9 ×	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2.	Physician/Med	IF FEMALE:	23c. If yes, outcome of	2,000,000,000,000					
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	Ectopic pregnancy	1		23d. Date of de Month	livery Day Year
P.O.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	ie or death 5∟	Other (specify) _				
٥.	that t ed by deta		Part II. Other significent conditions of	ontributing to death but r	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute lo	the cause of death?
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Sor	w requir been si should	ete						04- 146-	045 144	
Bě	has ge 2	Completed						24a. Was a autop perfor	sy prior to	utopsy findings available completion of cause of
ā	n: Ti ficate or, pa		25. Was case referred to medical					1 ☐ Yes	2 No 1 ☐ Yes	2 No
of Vital	ding Physician: The h. h. After this certificate ha funeral director, page	o Be	examiner?	Hospital:	2 ER/Outpatien	t 30 DOA Oth		th (Check only or	ne) ence 6 💆 Other (Spe	Econolodge,
of	Phy ar this aral d): To	27. Manner of Death	28a. Date of Injury	28b. Time of	1 30 DOX			ow injury occurred	CITY) EIKTON, MD
ö	th: Afte	tio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	January 3			Yes 2 No	Decelat	- hanged his	nealf
Division	I or Attendater deatl Director: I in by the	HC	3 Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury	- At home, farm, str			28f. Locetion (S	treet and Number or Ri	
Ö	al or	Certification:	4 Honticide	building, etc. (E conolod	ge Ro	om 108	311 Muc		= /kton MD
	To the Hospital or Attene within 24 hours after deatl To the Funeral Director: completely filled in by the	ai (29a. Certifier 1 Certifying Ph	sician: To the best of n	ny knowledge, death	occurred at the tin	ne, date and place	and due to the c	ause(s) and manner as	stated
	ns H	Medicai	(Check only 2. Medical Exemone)	iner: On the basis of ex and manner stated	amination and/or inv 1.	estigation, in my o	pinion, death occu	rred at the time, d	late and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (Mont	h, Day, Year)
	4		1H. Perken	MD		10 19	7314	3	imuary 5.	2005
	4		30. Name and address of person who	completed cause of deat	h (Item 23a) (Type,	Print)	11.4		7 7	
_	1		H Farkes, M	D Union	h (Item 23a) (Type,	tal, El.	Kton,	MD		
6.	Sta		31. Date filed (Month, Day, Year)	32. Fegistrar's	Signature	0.00				
	Registr	ar	JAN 0 - ZI	Jacobson States	o St. Jak	A Shaper of				

		•	For State Registrar	State of N	Maryland / De <i>C</i>	partmen <i>ertificat</i>	t of H e <i>of L</i>	ealth and Death		giene2 () Reg. No.	05	01253
			Decedent's Name (First, Middle, Last))					2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Catharine B. My	ers					January	7 04' 20	005	0946 M
	Examin		4a. Facility Name (If not institution, give	street and numbe	or)			Location of Dea	ıth	4c. County		
			Carroll Hospital				-	inster			arrol	
ı	Funeral Director		5. Social Security Number 6. Se 212-24-6443	x □ M 2□X = 7.7	Age (<i>In yr</i> s. last birthd 77 Yrs	Months	Days	If Under 24 Hr Hours Mir	s. 8. Date of Bir (Month, Da Oct 2!	1927	9. Birth	place (State or Foreign intry) MD
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location						10d. Inside City Limits
	larylarylarylarylarylarylarylarylarylary	5		7	Mos	tminst	or					1 Yes 2 ⅓ No
	28a-	Director	MD Carro1 10e. Street and Number	<u>L</u>	Wes	10f. Zig				10g. Citizen of	What Cou	intry?
	with 3a or		524 Morelock Sch	oolhouse	Road		211	58		USA		
	death	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S.	3. Was Dece	dent of Hi	spanic Origin? (n, Mexican, Pue	Specify Yes or No			can Indian,
9	or Ite	Fu	1 Never Married 2 Married	Armed Force 1 Yes 2 If Yes, Give		1 ☐ Yes	•	Specify:	ito nican, etc.)	Specil	ck, White,	
ဗ္ဗ	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or ltems 23a or 28a-f show event, I're Medical Examinat must be invitited at	d by	3 XWidowed 4 ☐ Divorced	Year or Date:	s:		202110				- VV.	hite
L	72 h "natu	Completed	15. Decedent's Edu (Specify only highest grad		(G	ecedent's Usu- live kind of wo e. DO NOT u	rk done d	during most of w	orking	Board of B		ndustry
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<u>a</u>	should be in the Mental I marked o	To Be	Howard Aaron Ba	nkert				Rhoda :	Shipley			
Maryland 21215-0036	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (T) Kevin Myers/son	rpe, Print)	19ь. м 41	ailing Address 86 Mid	(Street a	and Number or F	Rural Route Numb	er, City or Town Bridge,	, State, Zij , MD	21791
ē,	s 1 and 2 f Health Item 27 other tra	1	20a. Method of Disposition		20b. Place of Di	sposition (Na	ne of	01/0	07/2005	20c. Location	- City or T	own, State
Ë	Page: ent of nt: If I	1	1 ☑ Burial 2 ☐ Cremation 3 ☐ B '4 ☐ Donation 5 ☐ Other (Specify,					1 Garde	ns	Fink	ksbur	g, MD
altimore,	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Litens	90		Pritts	d Addres	erar Hor	me and Cl	napel, I	.A.	
m	88588		I John X ASIZ			412 Wa	shin	gton Ro	ad Westr	minster,		21157
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caus ne cause on each	sed the death. Do not n line.	enter the mod	le of dyin	g, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between
	Pnysician	8 1	Immediate Cause (Final disease or condition	PY	chable	my	Ca	rdial	intar	ctw	2	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):	, ,		7 /	10:	10 Per .		
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9	tifical ng ph as th	0	IL CELLULE.					-	-			
Вох	leath certific attending pi	an/N	23b. Was decedent pregnant	23c. If yes, outcor 1 ☐ Live birth	me of pregnancy 2 Fetal death	3 □Ectopic p	regnancy				ate of deliv	very Day Year
	that the death cer ed by the attendin detached for use	Physiclan/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant 9□Unknowr	t at time of death	5 Other (s)	pecify)			101	31161	Day Four
P.0	hat th ad by detacl	Ph)	Part II. Dther significant conditions of	ntributing to deat	h but not resulting in th	e underlying	ause giv	en in Part I.	23e. Did	obacco use con	tribute to	the cause of death?
Vital Records,	es De	d by				, ,			10	Yes 2 No	3 🗌 Pro	bably 4 DUnknown
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Re	The law	ошо								psy prmed? 20 No	death?	ompletion of cause of
ta		0	25. Was case referred to medical					26. Place of D	1 ☐ Yes eath (Check only		1 1 1 1 0 3	20110
	Physiclan: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🗙 No	Hospital: 1 ☐ Inpa	atient 2.ER/Outpa	atient 3 De	Oth Oth	er: 4 🗆 Nursing	Home 5 ☐ Res	dence 6 Ot	her (Speci	ify)
0	g Phys ter this neral di		27. Manner of Death 1 Natural 5 ☐ Pending	28a, Date of I		e of	28c. Injun Wor	y at k?	28d. Describe	how injury occu	rred	
<u>Sio</u>	Attending in death.	atlc	2 ☐ Accident investigation			М	1 🗆	Yes 2 No		-		
Division of	or Att after de Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place UI	Injury - At home, farm etc. (Specify)	, street, factor	y, office			Street and Num wn, State)	ber or Rur	al Route Number,
	Hospital 24 hours a Funeral I tely filled		29a, Certifier 15 Certifying Phy	vsician: To the be	est of my knowledge, o	leath occurred	at the tin	ne, date and pla	ce, and due to the	cause(s) and m	anner as	stated.
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Exam	iner: On the basi and manner	s of examination and/o	or investigation	, in my o	pinion, death oc	curred at the time,	date and place,	and due t	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29	c. Licens	e number		29d. Date signe	(Month	Day, Year)
	WIZ		1 W/au	reen	(et u	1	D4	3962		1/	4/	05
	Wig		30. Name and address of person who o	completed cause		4 2		701.	0 1.20	thaus-	101	, MD 21157
			31. Date filed (Month, Day, Year)) M.D.	130 Bo	Him	Dre	- 15100	L Wes	N VVIIVI >	CC	1115/
	Sta Regist		JAN 0 5	000	Unsua S	Loon	ري					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 0 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Year **Physician** 2005 MARKEY /Medical ELNORA ELIZABETH anuary 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula legional Medical Center If Under 1 Year If Under 24 Hrs. Wiconico Funeral 5. Social Security Number Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 XE Min Director 205-16-5726 1 - 8 - 26PA Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12542 Old Bridge Rd. 21842 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes Z No Specify: White 3 Widowed 4/Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manager Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry B. Markey Margaret Markey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an item 27 l 12542 Old Bridge Rd., Ocean City, Md.,21842 Brady S. Bowman son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State ortant: If it 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Berlin, Md. Sunset Mem. Park 21. Signature of Funeral S 22. Name and Address of Facility Depa Import any in Ullrich Funeral Home Berlin, Md. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician DAY J disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA DAYS Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The taw requires that the death certificate be executed PSEUDO MONAS 30 DA41 Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, STENOSIS 1 Yes 2 No 3 Probably 4 Unknown Be Completed HEART ONGESTIVE 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death Check onl one examiner' 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other. 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification; To 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural s after dea. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JANUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REGIONAL MEDICAL CENTERIMD 21081 M.D. PENINSULA M. SHIRAZI gistrar's Signature State 5 2005

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth ^{Day} , 2005 **Physician** January 4:40 P.M Mary Wildasin McGuinness /Medical 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Williamsport Nursing Home Williamsport Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign (Month, Day, Yeer) | November 24,1915 | Maryland 5. Social Security Number 7. Age (In yrs. last birthdey) 6. Sex **Funeral** Months Deys 1 □ M 2 👿 F 89 216-14-6536 Director Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or heme 23e or 28e-f ahow any injury or other traumatic event, The Medical Exeminar must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ (No Maryland Funeral Directo Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 11322 Greenberry Road 21740 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X ☐ No Specify: Specify: White Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Medical Asssistant Doctors Office 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Ralph Clefton Bond Mary Elizabeth Wildasin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 11322 Greenberry Road, Hagerstown, Md. 21740 Kathleen B. McGuinness Daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Antietam National Cemetery 01-06+05 Sharpsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Andrew K. Cottman Funeral nume, 1116.

40 East Antietam Street, Hagerstown, Md
Approximate Interval Between Onset and Death Andrew K. Coffman Funeral Home, Inc. poel Brao Md. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) ZWEERS /Medical Examiner Due to (or as a consequence of) Examiner attanding physician and for usa as the bunal-transit Hospital or Attanding Physician: The law requiras that tha daath certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 X No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Vos 2 7No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Medical Certification: To 1 ☐ Yes 2 No 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month. Dav. Yeer) 29b. Signature and title of certifier 29c. License number 3370C completed cause of deeth (Item 23e) (Type, Print) of person who 15 WILLIAMSPOR N. ARTIZAN ST. SH-4 TED HOWE 32. Registrar's Signature 31. Dete filed (Month, Day ^{Year)} 6 State 2005 Registrar

			1 - For State of Maryland / Dep	eartment of Heal		ntal Hygien	2005	01256
	Physicia		Decedent's Name (First, Middle, Last) Mabel Evelyn MILLER		2	. Date of Death Month D	Pay Year 4, 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loca			tc. County of Death Washingt	h
	Funeral		Washington County Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday			. Date of Birth (Month, Day, Yea		hplace (State or Foreign untry)
Ì.	Director		213-40-6606 1 M 2 TF 87 Yrs.	Months Days Ho	Miri.	March 22,	1917 Io	
	aryland show	'n	10a. State 10b. County 10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 ☒ No
	r 28a-f	Funeral Director	Maryland Washington Bo 10e. Street and Number	onsboro 10f. Zip Code		10g. C	Citizen of What Co	
	ath with	raiD	18229 Manor Church Road	21713			USA	
920	urs after de al', or Itams raminer n	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:	. Was Decedent of Hispan If Yes, specify Cuban, Me 1 ☐ Yes 2 X No Sp		fy Yes or No- can, etc.)	14. Race - Ame Black, White Specify:	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dept iment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic avant. The Medical Evariate must be notified at once.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during DO NOT use retired) .emaker	g most of working		Kind of Business/l	·
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Maryland	should be nd Mental markad o	To	Percy Moore Myers	ling Address (Street and N		Alice Fo		7:- O- 1-\
	and 2 st Balth and n 27 is n		1 1 1 1	46 Lappans F				
Baltimore,	Pages 1 and of He nent of He nut: If itam			ematory or other place)	Dat 1/7/0		Location - City or	Town, State , Maryland
altin	permit. Pa Depertmer Important any injury		'4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	nurch of the ren Cemetery 22. Name and Address of		NNICH FUN		
Ä	Deprini Deprini Impo		Test M//muce	415 E. Wilso	on Blvd.	, Hagerst		21740
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition each in death) a	andiampop	athy	espiratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner	-	Due to (or as a consequence of):	nosis	9			years
	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c. 41	nosis				Jeons
8760,	icate be executed physician and s the burial-transit	dical Ex	resulting in death) Last Due to (or a la consequence of): d.	e mellet	lus			yeans,
.O. Box 6	The law requires that the death certific lie has been signed by the attending p page 2 should be detached for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)			23d. Date of deli	very Day Year
Δ.	quires that an signed b uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	ınderlying cause given in	Part I.		use contribute to	the cause of death?
Vital Records,		Completed	Colon Cemcer			24a. Was an autopsy performed?	prior to c	topsy findings available completion of cause of
	Physician: Th this certificate ral director, pag	o Be (25. Was case referred to medical examiner? 1 Yes	Other	Place of Death (0	Check only one)		.,,
n of		\vdash	1 Yes 2 No Ilospitation 2 ER/Outpatien 2 ER/Outpatien 27. Manner of Death 28a. Date of Injury 28b. Time Injury Injur	AIL 3 DOM 4	_	5 🗌 Residence d. Describe how inj		ary)
Division	To tha Hospital or Attanding within 24 hours after death. To tha Funaral Diractor: After completely filled in by the funer	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)	M 1 ☐ Yes		Location (Street a City or Town, Sta		ral Route Number,
_	tospital thours unaral	dical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	nvestigation, in my opinior	n, death occurred	at the time, date a	nd place, and due	to the cause(s)
}	To tha h within 24 To tha f complete	Me	30. Name and address of person who completed cause of death (Item 23a) (Type 203) 31. Date filed (Month, Pay, Year) 32. Registrar's Signature	29c. License num D 4 4	996	294. 0	ate signed (Month	n. Day, Year)
3	H-12		30. Name and address of herson who completed cause of death (Item 23a) (Type	Print) Cappan	rs Rd	Boonst	oro m	D 21713
0	Sta Registr	te ar	31. Date filed (Month, Pay, Year) 32. Registrar's Signature	perke				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2.0.0.

		•	For State Registrar	State of Ivia	iryland / Dep <i>Ce</i>	rtificate of	Death		4 U U)	0125
			Decedent's Name (First, Middle, La	st)				2. Date of Death Month	n Day Ye <i>a</i> r	3. Time of Death
	Physicia /Medic		Martha G. McFad	den				January		9:06 P M
	Examin		4a. Fecility Name (If not institution, giv	e street and number)		4b. City, Town,	or Location of Death		4c. County of Deeth	
			Montgomery Hospice	-Casey Ho	use	Rocky			Montgome	ry
	Funeral		5. Social Security Number 6. S		(In yrs. last birthday	Months Day	r If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Yeer) 9. Birth	place (State or Foreign intry)
	Director		179-05-2525	I □ M 2180 F	93 Yrs.			June 7,	1911 Pen	nsylvania
	yland		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Man -fah	ţō	Maryland Mont	gomery	Silve	er Spring				1 ☐ Yes 2 📉 No
	r 28e	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
	h with	0	3200 North Leis	ure World	Blvd.	2090	06		USA	
21215-0036	toges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If it is a 27 is marked other than "natural", or items 23a or 28e-f ahow if it is other traumatic avent, the Medical Evant, earthing to motified a confidence.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 I Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify:Whit	, etc.
9	72 ho	ted	15. Decedent's E (Specify only highest gra	ducation	16a. Dec	edent's Usual Occ	upation e during most of work	ina	16b. Kind of Business/Ir	ndustry
21	1.75	Completed	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retir	ed)	9		
	filed wi Hygien sther th	ő	7		Ho	memaker			Own Home	
nd	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, N	faiden Sumame)	
la	should but and Ment is marked umartic a	ဥ	John Lafferty				Catherin	ne Schile	đ	
Maryland	2 sho and Is my		19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ing Address (Stree	et and Number or Rur	al Route Number,	City or Town, State, Zi	^{p Code)} 20906
	and 2 ealth n 27		Edward Charles M	cFadden /					, Silver Sp	
Baltimore,	Part and		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		20b. Ptace of Disp cometer, co Parklay Memoria	ematory or other po 7N	Janua 200	ary 4	20c. Location - City or T	
Balt	permit. Pa Departmer Important any injury once.		21. Signature of Funeral Service Lice	Youl			ersity Blvo		Home Inc lver Spring	, Md 20901
le su	Physician		23a. Pert1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition	pplications that caused one cause on each ling Debilit	е.	nter the mode of d	ring, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death Months
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	ificate be executed g physician and as the burial-transit	каш	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
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87	ohysi the t	dlea		d						
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ds,	w requires that s been signed to should be deta	Completed by						1 ☐ Ye	s 2₹ΩNo 3∏Pro	babiy 4 Unknown
Ö	requ been shoul	ete						240 1450 00	Odb Wass aut	findings qualitable
3ec	elaw hasb je2sh	m						24a. Was ar autopsy perform	v prior to co	opsy findings available ompletion of cause of
1	: The cate has page	ပိ						1 ☐ Yes 2	∑XNo 1 ☐ Yes	2 No
/its	ysician: The laviscertificate has director, page 2	Be	25. Was case referred to medicat examiner?	Hospital:			26. Place of Deal			
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n O		on	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Day	Year) 28b. Time Injury	W		280. Describe no	w injury occurred	
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	To the Hospital or Attend within 24 hours after death to the Funerel Director: completely filled in by the	Medical C	29a. Certifier 1 A Certifying Pl (Check only one) 2 Medical Exa	hysicien: To the best of miner: On the basis of and manner sta	examination and/or	ith occurred at the nvestigation, in my	time, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner as ite and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	,		29c. Lice	nse number	29	d. Date signed (Month)	Dey, Year)
	3		I chrise	Jayme-			D42452	3	January 3,	2005
			30. Name and address of person who						VLERE	
			Chitra Rajagopa	1, M.D. 6	001 Muncas	ter Mill	Road, Roo	kville,	MD 20855	
			31. Date filed (Month, Day, Year)	T		parti				

		1 - For State Registrar		aryland / Depa			lental Hygi	ene g. No.20	05 012
Physici		1. Decedent's Name (First, Middle, Thomas	Last) M	Magoon			2. Date of Death	Day	Year 3. Time of Dea
/Medic Examin		4a. Facility Name (If not institution,		10017	4b. City, Town, o	r Location of Death	January	4c. County of	005 11:30 F
LAGIIII		Renaissance Gard		wood Villag	Silve	r Spring			gomery
Funeral			_	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)	9. Birthplace (State or For Country) New Hampshir
Director		026-18-6098	1 X M 2	82 Yrs.	- Suy o	110010	July 14,	1922	New Hampshir
and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Li
Heh Hed	ţō	Maryland Mon	tgomery	Silver	Spring				1 ☐ Yes 2X
ueain with the maryland ms 23a or 28a-1 chow I must be rollified at	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wi	hat Country?
23a o	aiD	3142 Gracefiel	d Road, #52	1	209	904		US	A
sme	ner	11. Marital Status	12. Was Decedent B	Ever in U.S. 13.1	Was Decedent of H	ispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-		- American Indian, , White, etc.
or le	by Fu	1 Never Married 2 Married		lo)	1 ☐ Yes 2 K No		riiodii, oto.)		White
la la	q pe	3 Widowed 4 Divorced			1				
na Perilic	Completed	15. Decedent's (Specify only highest	grade completed)	16a. Decec	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of worki 1)	ing 1	6b. Kind of Bus	iness/Industry
ene Than	mo	Elementary/Secondary (0-12)	College (1-4or 5 5 +	+)	ofessor	'/		Educa	tion
othe ent,		17. Father's Name (First, Middle, La	ist)			18. Mother's Name	(First, Middle, M.		
fenta rked tic ev	To Be	Mayo Magoon				Katheri	ine Under	rwood	
s ma		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	g Address (Street	and Number or Rura	l Route Number,	City or Town, S	tate, Zip Code) 2090
n 27 l er tre		Mary C. Magoon	/ Wife	314	2 Gracefi	ield Road,	, #521, \$	Silver	Spring, MD
or oth		20a. Method of Disposition 1 □ Burial 2 Toremation 3	□ Bomoval from State	20b. Place of Dispo	sition (Name of natory or other plac	Jan.	oate 6,	0c. Location - C	ity or Town, State
ment ent: I		`4 □ Donation 5 □ Other (Spe		Metropoli		1	04	Alexand:	ria, Virgin
point. Tages I late a should be find within 72 flours after beath with the marylan bonner. Tages I late and Medial Hygione. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be notified at once.		21. Signature of Funeral Service Lie	Parka	22 F 5	Name and Address Tancis J.	Collins	Funeral	Home I	nc pring, MD 20
The tark requires that the death certificate be executed to the alternation death and the attended for use as the burial-transit and the detached for use as the burial-transit.	licai Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	ration a consequence of): Sep515	_	g, such as cardiac o		st,	Approximate Interval Between Onset and Deat
ned by the attending prodetached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date Month	,
signed t	by	Part II. Other significant conditions			derlying cause give	en in Part I.			ute to the cause of death
been s	eted	Univary	Major 1	η ν			1 ☐ Yes	2 N o 3	☐ Probably 4 ☐Unkno
	Completed	Coronary	artery	clisia	Se		24a. Was an autopsy performe	prid?	ere autopsy findings available to completion of cause ath? Yes 2 No
this certificate	Be (25. Was case referred to medical examiner?				26. Place of Death		· · · ·	
this o	<u>٩</u>	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatier			4 Marianing Hon	ne 5 🗆 Residen	ce 6 □Other	(Specify)
h. After funera	on	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injun (Month, Day	Year) 28b. Time of Injury	28c. Injury Work		8d. Describe how	injury occurred	
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s after death. I Director: After In by the fune	Certification:	4 Homicide determine	building, etc.	ry - At home, farm, stre . (Specify)	et, factory, office	2	City or Town,	et and Number State)	or Rural Route Number,
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To the	Me	29b. Signature and title of certifier	7 (0		29c. License	number	290	I. Date signed (i	Month, Day, Year)
1		> Loveen	Puthuma	ua. HD	D59	524	J	anvar	y 3,2005
ot!		30. Name and address of person wh	o completed cause of de	ath (Item 23a) (Type, I	Print)				
Cha		31. Date filed (Month, Day, Year)	UMANA 311	's Signature	IELD KOA	D SILVE	K OPKIN	עוזיי, מ	20404
Sta Registra		and the same of th	2005	r's Signature	we				

			for State		land / Dep	artment	of Health and N			nne.	01050		
			1 State Registrar		Ce	rtificate	of Death		g. No.	000	01239		
	Physici	an	Decedent's Name (First, Middle, L Fig.	ANNIE SUE MII	LER			2. Date of Death Month January	Day,	2 00 5	3. Time of Death 10:30 A M		
	/Medic		4a. Fecility Name (If not institution, gi			4h City T	own, or Location of Death	L		unty of Death	10.30 A		
1	Examir	ier	13036 Brice Road	vo stroot and nombor,			nurmont		40.00	Freder	d old		
	Funeral		Social Security Number 6.	Sex 7. Age (Ir	yrs. last birthday)	If Under 1	Year If Under 24 Hrs.	8. Date of Birth	Vanel	0.0:46	In /Ota ta		
	Director		240-32-6644	1□M 2XF	76 Yrs.	Months	Days Hours Min.	Apr. 24	, 192	28 Nort	try) h Carolina		
	pu k		Usuel Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	tion							
	ehov	5								1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No		
	the M	ecto	Maryland Frederi	LCK	Thurmon		\.d.		2 000	(110 . 0			
	with	Ö	13036 Brice Road	1		10f. Zip (21788	"		of What Coun	try r		
	72 hours after death with the Maryland natural', or Itame 23a or 28a-1 ehow dical Exandrat must be invilled at	Funeral Director	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decede		ecriv Yes or No-		Race - Americ	an Indian.		
'n	ritar	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No	i i		nt of Hispanic Origin? (Sp y Cuban, Mexican, Puerto	Rican, etc.)		Black, White,			
93	ral', o	by	3X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	XNo Specify:		Sp	ecify: Wh:	ite		
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anc	d be find he do	Be	Johnny Norfleet G					e (First, Middle, M		mame)			
Ž	d Me d Me mark matic	은	19a. Informant's Name/Relationship		10h Maili	an Address /		oma Barru		C4-4- 7:	0-4-1		
Maryland	d2s th an trau		Melanie Kovera (I				Street and Number or Run Countain . Road						
	Heal Heal tom 2		20a. Method of Disposition					-					
JO L	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar ariment of Health and Mental Hygiene. Ortant: If item 27 is marked other then "natural", or Itams 23a or 28a-1 ehow injury or other traumatic event, the Medical Examener must be conflired at injury or other traumatic.		1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)										
Baltimore,	permit. Page Department of Important: If eny injury or		Resthaven Mem. Gardens 1/5/05 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility OBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 FAST MAIN STREET THURMONT MD 21789										
ä	Depa Impo eny i		P. ItE	Till	KO 61	BERT E 5 EAST	. DAILEY & S MAIN STREET	SON FUNER	RAL H	OMES, E	.A.		
ř.	हे		23a. Part 1. Enter the disease, or con	polications that a used the	death. Do not ent	er the mode	of dying, such as cardiac	or respiratory arre	st,	MD 2176	Approximate		
	Physician		23a. Part 1. Enter the disease, or complications the used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final										
	/Medical		disease or condition resulting in death)	a. Lue to (or as a co	ns prence of):	1	X	m	1		110		
	Examiner		Conventinity link and distance	Fry S	tanc (Lun	Luc Olis	turtu	ιli	ing 1	6 morth		
	P =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co	isequence of):				Λ.	-1			
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c					New	en			
760,	icate be executed physician and s the burial-transit	Ü	rosuming in doutry Last	Due to (or as a co	nsequence of):								
687	cate t	dicai		d									
9 ×	ding	Physician/Med	IF FEMALE:	23c. If yes, outcome of pr	egnancy				1				
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	The law requires that the death certifica te has been signed by the attending phy bage 2 should be detached for use as th	y P	Part II. Other significant conditions	contributing to death but no	t resulting in the u	nderlying cau	se given in Part I.	23e. Did toba	acco use	contribute to th	e cause of death?		
Records,	quires n sign	d by	Corona	m auto	5 1	ses	4	1 XYes	2 □ N	o 3 🗆 Proba	ably 4 Unknown		
Ö	w requires been si	Completed	1 de la cont		0			24a. Was an	24	tb. Were autor	sy findings available		
Re	he lav e has age 2	mc	- A X Joen					autopsy perform	ed?	prior to con death?	npletion of cause of		
Vital		0	25. Was case referred to medical				26 Place of Death	1 Yes 2	XN0	1 🗆 Yes	2 LJ N0		
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o C	19 Ph	T:U	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time of		·	28d. Describe hov			,		
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Ω	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:											
	Hospita 24 hours Funeral	edicai	(Check only 2 Medical Exa	nysician: To the best of my miner: On the basis of exa	knowledge, death	occurred at	the time, date and place, my opinion, death occurr	and due to the cau	use(s) and	manner as sta	ated.		
	To the k within 2 To the f complete	Med	(A)	and manner stated.									
	To To cor		29b. Signature and title of certifier	(/	1/11/1	290.	license number	290	a. Date si	gned (Month, L	vay, rear)		
1	0		- Cun	June	WWW) [718107		11	3/05			
1	3		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print)			,	1			
	Sta	tate 31. Date filed (Month, Pay Year) 2011 32. Registrar's Signature											
	Pogistr		JAN U D	20u: N	- Ad A	Sorgado 1							

				Type or Print in Bla State of Maryland				•		egible.	
			1 - State Registrar			rtificate of		F	eg. No	005	01260
	Physici		1. Decedent's Name (First, Middle, Last,	1 1	lina			2. Date of Dea Month	Day	Year 2005	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, give				r Location of Deat		4c. Co	unty of Death	
	Funeral	-	Anne Arundel Medic 5. Social Security Number 6. Sec	cal Center x 7. Age (In yrs. Ias	t birthday)	Annapo If Under 1 Year	If Under 24 Hrs		1	ne Arun	lace (State or Foreign
	Director		171-07-5221	90 ≥0 P	Yrs.	Months Days	Hours Min.	Dec. 2			nsylvania
	yland		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Town or Lo	ecation				1	Od. Inside City Limits
	8a-fel	Director	Maryland Anne Aru	indel Anna	apoli				IOn Citizan	of What Cour	1 ☐ Yes 2√2 No
	3a or 2		10e. Street and Number	170		10f. Zip Code 21403				d State	
	death	Funerai	266 Hillsmere Dri	12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of H	lispanic Origin? (S			Race - Americ Black, White,	an Indian,
920	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show mixportant: If Item 27 is marked other then "natural", or Items 23a or 28a-f show yill injury or other traumatic event, Ite Medical Examination in an ange.	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Ppivorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 % No	Specify:	, , , , , , , , , , , , , , , , , , , ,		ecity: whi	
215-0036	72 ho	eted	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup	during most of wo.	rking	16b. Kind	of Business/Ind	dustry
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	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Ma	Be C	12 17. Father's Name (First, Middle, Last)			<u> </u>		me (First, Middle,	Maiden Sui	тате)	
yla	should be nd Mental I marked o umatic eve	2	Vian Shaw	0.00	405 14:22	ng Address (Street	Vera Ea		. City of To	Ctata 7in	Codel
Maryland	id 2 sh lth and 17 is m traum		19a. Informant's Name/Relationship (Ty			Hillsmer			MD 21		Code)
Ē,	of Health of Health of Item 27		Wayne Meckling/ so 20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of matory or other place		Date		ion - City or To	wn, State
Baltimore,	Peges ment of I		1 Donation 5 Other (Specify)	Hil		t Cemete	ry Jan	5, 2005	Armag	olis.	MD COM
Balt	permit. Peges Department of Important: If I any injury or once.		21. Signature of Funeral Service Licens	ans within		. Name and Addre					l Home, Ind MD 21401
j.	*		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	lications that caused the death.						iporra/	Approximate Interval Between
1	Physician		tmmediate Cause (Final disease or condition	partins	ک' ہن	disci	ase				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequen	nce of):						
	6.	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequen	nga o/):						
	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (er se a consequen	f\-						
		<u>a</u>	Toodhing in additi) East	Due to (or as a consequen	ice or):						
687	tificate ig phys as the	ledic		0							1,077
O. Box	that the death certificate ted by the attending physic detached for use as the test and t	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown	ath 3	Ectopic pregnancy Other (specify)	<i>'</i>		23d.	Date of delive Month	ny Day Year
s, P.O	es that tigned by	by Ph	Part II. Other significant conditions con	ntributing to death but not resulting	ng in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use	contribute to th	e cause of death?
ords	w require been sig should b							1 🗆 Y	es 2□N	o 3□Prob	ably 4 ∰Unknown
Record	has has	Completed						24a. Was a autop: perfor	SV	prior to cor death?	psy findings available inpletion of cause of 2 No
		Bec	25. Was case referred to medical examiner?					ath (Check only or	10)		
of V	Physician: this certificantal director.	ို	1 ☐ Yes 2 ☐ Mo	Hospital: 1 ☐ Inpatient 2 ☐ ER			4 Nursing F	lome 5 ☐ Resid			1)
ion c	anding P bath. or: After t ne funera	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28 (Month, Day Year)	3b. Time of Injury	Wor	yat k? Yes 2 ∐No	28d. Describe h	ow injury od	curred	
Division	el or Attendi s after death. Il Director: A ad in by the fu	Sertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and N n, State)	umber or Rura	l Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical (sician: To the best of my knowle ner: On the basis of examination and manner stated.							
	To the within 2 To the complet	Me	29b. Signature and title of certifier	201		29c. Licens	e number	2	9d. Date si	gned (Month,	Day, Year)
			» r und ji	omploted cause of death (line of	3a\ /T~	Print)	10 7		21/0	1/05	
			30. Name and address of person who co	alta 132 H	tolid		507	te 201	Ar	napili	s MD
	Sta Registr		31. Date filed (Month, Day, Year)	32 egistrar's Signature	θ						

			For Stete Registrer	State of M	aryland / Dep	artment		h and M		_) 5	01	261
	Discosio:		1. Decedent's Name (First, Middle, L	ast)					2. Date of Death Month	_	/221	3. Time o	f Death
	Physici /Medic		Mary Margare						January	9 200	rear)5	2:50	O A M
	Examin	er	4a. Facility Name (If not institution, g				own, or Locati			4c. County of			
			Homewood Retire 5. Social Security Number 6.		e r ge (In yrs. last birthday		lliamsp	ort ider 24 Hrs.	9 Date of Birth		ningt		
	Funeral Director		214-46-5664 Usual Residence of Decedent	1□M 2X F	97 Yrs.		Days Hou		8. Date of Birth (Month, Day, Apr.19,	Year) 1907	Counti Mar	ece (State ory) y land	r r-oreign
	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show dical Exam me matter indiffed at		10a. State 10b. County		10c. City, Town or L	ocation					10	d. Inside C	
	Ba-f s	cto	Maryland Wash	ington	W	illiams	sport					1 🗌 Yes	2 🗶 No
	with the	by Funeral Director	10e. Street and Number		400	10f. Zip (10	g. Citizen of Wh		ry?	
	eath	eral	16505 Virginia	12. Was Decedent		Was Decede	21795		acifu Vas or No.	14. Race	USA	n Indian	
' O	fter d r Item	Fun	1 Never Married 2 Married	Armed Forces'	?			cican, Puerto	ecify Yes or No- Rican, etc.)		White, et		
03	rel', o	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □ Yes 2)	XXNo Spec	cify:		Specify:	W	hite	
5-0	72 h	Completed	15. Decedent's (Specify only highest g	Education rade completed)	(Giv	edent's Usual e kind of work	done during r	most of work	ing 1	6b. Kind of Busi	ness/Indu	ustry	
121	within ene. then "	mpl	Elementary/Secondary (0-12)	College (1-4or	5+) life.	DO NOT use				2			
Maryland 21215-0036	filled Hygi ther		17. Father's Name (First, Middle, Las	st)			armer 18. M	other's Name	e (First, Middle, Ma		ricul	ture	
lan	should be nd Mental markad o	To Be	John Eve r ett	Noody									
ary	shou and M s mar)	19a. Informant's Name/Relationship		19b. Mail	ling Address (Street and Nu	mber or Rura	Susan E al Route Number, e	City or Town, St.	ate, Zip C	Code)	
Σ,	permit. Pages 1 and 2 should be Depurment of Health and Menta Important: If item 27 is marked any njury or other treumatic enones.		Ruby O. Byers -	Friend	121	18 Gree	encastl	e Pike	e Hagers	stown, M	lary I	and	21740
Baltimore,	of He		20a. Method of Disposition XXBurial 2 ☐ Cremation 3	☐Removal from State	20b. Place of Disp cemetery, cre	osition (Name amatory or oth	e of ner place)		Date 20	0c. Location - Ci	ty or Tow	n, State	
Ē	Pag ment tant: jury c		`4 □ Donation 5 □ Other (Spec	ify) V	Rose Hil				1,2005 Ha	gerstow	n, M	lary la	ind
3ai	Departition Depart		21. Signature of Fureral Service Ut	ny A					ne, P.A.				
1	25 = 6 Q		23a. Partit Enter the disease, or co	molication, that cause	d the death. Do not or	425 S.	Conoco	cheagu	ue St. Wi	lliamsp		MD 2 Approximat	1795
М	al an		shock, or heart failure. List onl	y one cause on each I	ine.	A THOUSAND	R Such	as cardiac c	1		l l	nterval Bet Onset and I	ween
	Pnysician /Medical		disease or condition resulting in death)	a	a consequence of):	CFI	1014	BIT	(AVICE	N	-		
	Examiner				a consequence ory.	DIT	H 101	L(A)			/	IFT >	×5
		ner	Sequentially list conditions,	b. — Dua to (or as	a consequence of y		101)		- 0	neti ei	2(1)
	nd nd transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c									
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ထ	physics the b	dical		d							-		
9 X	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy					OOd Date	d ataliana		
Вох	atter d for u	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ NO		2 Fetal death 3	□Ectopic pred □ Other (spec				23d. Date of Month			Year
o.	t the c by the achec	hysi	9 Unknown	9□ Unknown									
S, G	signed d	by P	Part II. Other significant conditions	contributing to death I	out not resulting in the	inderlying cau	use given in Pa	art I.	23e. Did toba	cco use contribu	ute to the	cause of d	eath?
ord	w require been sig should b	ted	FOR (A)	1BACCCU	The I	WCE/10	OSCCE	NOT	1 ☐ Yes	2 40 3	Probab	oly 4 □L	Jnknown
Records,	e law re has be ge 2 sh	Completed	- HEART DISE	7950.	Haporra	50-01			24a. Was an autopsy	24b. We	re autops	y findings a	available
		Con			, •				performe	dea	th?	□No	
Vita	Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				lace of Death	(Check only one)				
	Phys this ral dir	2	1 Yes 2 No 27. Manner of Death	28a. Date of Inju				-	ne 5 Residen		(Specify)		
Division of	ding th. After fune	tlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Injury	M 200	c. Injury at Work? 1 Tyes 2		28d. Describe how	injury occurred			
/ISI	l or Attending Physiater death. Director: After this in by the funeral di	ertification:	3 Suicide 6 Could not	be 28e. Place of In	jury - At home, farm, st				28f. Location (Stre	et and Number	or Rural F	Route Num	ber,
	s afte	Cert	4 Homicide	building, e	c. (Specify)	,			City or Town,	State)			
	To the Hospital or A within 24 hours after To the Funerel Directorphile in bit of the funerel Directorphile in bit of the funerel bit of the funerel full of the full of the funerel full of the full of the funerel full of the f	edical (29a. Certifier 11 Certifying P	Physicien: To the best pminer: On the basis of and manner st	of my knowledge, dea of examination and/or in ated.	th occurred at nvestigation, in	t the time, date n my opinion, o	and place, a death occurre	and due to the cau ed at the time, date	se(s) and manne e and place, and	er as stated due to the	ed. ne cause(s)
	To the comp	Me	29b. Signature and Ute of certifier		X	29c.	Libeose numb	er	290	I. Date signed (A	Month, Da	y, Year)	_
)			TING! K	ED (CAL	1) (AKCTAN		1) [10%)	11101	1200	7	
50			30. Na and ad s of per who	completed cause of	leath (Item 23a) (Type	Pright)	2/4	1	4			1.	1
5	4.3		31 Data filed (Months Par	(Cara, M) /4)	MON	your	HIL	THO	GISTER	NUN	, W	46_
77	Sta Registr	-	31. Date filed (Month Dax Year)	2005	ar's Signature	seeke				•) (سر و	06	
\$0			GRA SMF etc.		1						-1/	77	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 01262 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day June R. Nickens 8:10 p^M 3, 2005 /Medical January 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Fairland Nursing Center Silver Spring

If Under 1 Year | If Under 24 Hrs

Months Days Hours Min. Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F Director Yrs 579 38 7121 May 23, 1927 Mississippi Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location lem 27 is marked other then "neturel", or items 23a or 28e-1 show other traumatic event, the Medical Event, normust be notified at 10d. Inside City Limits MD Prince Georges Director Hyattsville 1 TYYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6305 Riggs Road death 1 20783 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 Is marked other then "neturel", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 → No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 3 € No Specify: Specify: White 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alfred Turney Hazel Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ent: If Item 27 Is Janis Benson-El Daughter 4603 7th St., NE Washington, DC 20017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ŏ permit. Page Department of Importent; If eny injury or once. `4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem \ 01/07/05 Suitland, Maryland 21. Synature of Funeral Service Licenses 22. Name and Address of Facility John T. Rhines Company 3015 12th Street, NE Washington, DC 20017 LUM n1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final **Physician** Congestive Heart Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician ian/Medical the attending IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year Physici 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed? certificate I 1 Yes 2 🗆 No 1 🗌 Yes 2√□ No To the Hospitel or Attending Physicien; within 24 hours after death. To the Funerel Director; After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 2 Accident investigation М 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52261 January 4, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD Alan R. Segal, MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 0 7 2005 Registrar

			1 - For State Registrar	Sta	ite of N	<i>l</i> larylan	-	artmen rtificat			and M	lental Hy	giene	000		0126	0
	Physici /Medi		Decedent's Name (First, Midd MARGARET A.	nie, Last) NICHOI	SON							2. Date of Dea Month Januar	Day	200	у _{еаг} 5	3. Time of Death 3:40A.	ð 1
	Examir	ner	4a. Facility Name (If not institution Conflor Convalesce	ent & Reh	abilit	ation (Crof	ton	Location of				County of	Arun		
	Funeral Director		5. Social Security Number 578-09-0346 Usual Residence of Decedent	6. Sex 1 □ M 2		Age (In yrs. I	93 Yrs.	If Under Months	Days	If Under Hours	Min.	B. Date of Birt Month, Da Jan, 23	, 191	1	9. Birthp Cour Mary	place (State or Foreign http) Land	n
	e Marylan 3a-f show	ctor	10a. State 10b. Count Maryland Anne	Arunde	el		Croft								1	0d. Inside City Limits 1 ☐ Yes 2 🗖 No	
	ath with th	Funeral Director	109. Street and Number 1874 Harcourt	Avenue				10f. Zip	Code	211	14		-	ted S		•	
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28a-f show early injury or other treumatic event, the Medical Example are must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Ma 3 🏋 Widowed 4 □ Divorce	rried 1 [s Deceder ned Forces Yes 2 () es, Give ar or Dates	₹No		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Orion, Mexican Specify:	gin? (Spe , Puerto	ocify Yes or No- Rican, etc.)			White,	an Indian, etc. hite	
Baltimore, Maryland 21215-0036	d within 72 ha jiene. r then "natu the Medical	Completed	15. Decede (Specify only higher Elementary/Secondary (0-12)		leted) lege (1-4o	r 5+)	16a. Deced (Give life. I House	kind of wor DO NOT us	l Occupa k done d e retired	ation Juring most)	of worki	ng		nd of Busi OWn l		,	
/land	uid be file Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle Joseph Hardy	Last)						18. Mothe Emma		(First, Middle, gels	Maiden	Sumame)			
, Mary	and 2 sho ealth and I m 27 Is me		19a. Informant's Name/Relation Janet Lee Well				1874	Harco	urt	nd Numbe Avenu	r or Rum 1e Ci	Route Number cofton,	r, City or Mar	r Town, st yland	ate, <i>Zip</i> 1 21	Code) 114	
timore	tent: If ite		20a. Method of Disposition 1 □Qurial 2 □ Cremation '4 □ Donation 5 □ Other (Specify)	I from Stat	e ce	lace of Dispo emetery, cren t Linc	oln C	her place lemet	ery 1	1/5/2		Brent	cation - Ci	l, Ma	arvland	
Ba	permit Depar Impor eny in		21. Signature of Funeral Service	Bages	and	4	D0 44	na Id 00 Po	Addres V E WCE	s of Facility Orgwa [M111	rgt Roa	Funeral d Belts	L Hor	ne, P Le, M	A. lary	land 20705	5
	Physician /		snock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death		
8760,	icate be executed Example physician and sthe burial-transit earth	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	b	ue to (or a	s a consequ	ence of):										
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₽.	w requires that been signed b should be deta		Part II. Other significant conditi Dementia	ons contributin	g to death	but not resu	Iting in the un	derlying ca	use give	n in Part I.			bacco us			e cause of death?	
Il Records,		Completed										24a. Was a autops perform	sy	prio dea	r to com	esy findings available appletion of cause of	
Division of Vital	To the Hospitel or Attending Physicien: The within 24 hours alter death. Ct the Funerel Director: After this certificate completely filled in by the funeral director, pag	ation; To Be		Hospital 28a.	1 ☐ Inpat Date of Inj (Month, D	iury	ER/Outpatient 28b. Time of Injury		c. Injury Work	r: 4[X]Nur	sing Hon	(Check only on the 5 Reside 8d. Describe ho	ence 6		(Specify)		
DIVIS	e Hospitel or Attending 24 hours after death. 9 Funerel Director: After etely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 288.	building, e	etc. (Specify)						8f. Location (St City or Town	n, State)				
	To the Hosp within 24 hou To the Funer completely fill	Medical	one)	and	To the bes the basis manner s	or examinati	vledge, death on and/or inv	estigation,	in my op	nion, deatr	piace, a occurre	nd due to the cad at the time, d	ause(s) a late and p	and manne place, and	er as sta I due to	ted. the cause(s)	
	3	2	29b. Signature and title of certifie	1	_m	D			License 3	S8	48	2		signed (A nuary		2005	
			30. Name and address of person Howard Schultz 31. Date filed (Month. Day, Year	, M.D.	1438	Defen	se Hiq	hway	Gamb	rills	, Ma	ryland	2105	54			
	Sta Registr		JAN 0	4 2005	32. Progist	trar's Signati	& A	arti					00	•			Ī

)	557		For State Registrar	State of Maryland / [artment <i>tificate</i>			nd M	-	- /\	005	n i	261
	Physici		1. Decedent's Name (First, Middle, Sergio	_{Lasi)} Vivar Ortega						2. Date of De Januar		005 ^{Year}	3. Time 0213	
	/Medio Examir		4a. Facility Name (If not institution, 7903 Good Luck R	give street and number)		46. City, 1 Lanha		Location of	Death		4c. Cou	inty of Death CE Geo	1	
	Funeral Director		5. Social Security Number none Usual Residence of Decedent	3. Sex 7. Age (In yrs. last bir 1 ☑ M 2 □ F 2 0	thday) Yrs.	If Under Months	1 Year Days	If Under 2	4 Hrş. Min.	8. Date of Bird (Month, Da 9 / 1 6 /	h y, Year) 1984		olace (State ntry) Kico	o <i>r Foreig</i> n
	Maryland a-f show life J at	tor	10a. State 10b. County	e George's Lan								1	l0d. Inside (City Limits
	death with the Maryland ms 23a or 28a-f show rinust be to titled at	al Director	10e. Street and Number 7303 Taylor	Street		10f. Zip (Code 2078	4			-	of What Cour	ntry?	
920	be filed within 72 hours after death with the Maryla nat Hygiene. od other than "natural", or Items 23s or 28s-1 shov event, the Medical Examber must be cutified at	by Funeral	11. Marital Status 1 ▼Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? d 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decede Yes, speci XYes 2				ecify Yes or No Rican, etc.)		Race - Americ Black, White, ecity: W		
Maryland 21215-0036	I within 72 ho iene. r than "natur the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(Give life. L		k done di e retired)	tion uring most o		ng		Business/In		
and 2	12 should be filed within h and Mental Hygiene. 7 Is marked other than "traumatic event, the Me.	Be	17. Father's Name (First, Middle, La	ast)		MICT 6		18. Mother's	s Name	(First, Middle,	Maiden Sun	ame)	= 00.	
lary	2 should and Me Is mark raumatic	2	Juan Vivar 19a. Informant's Name/Relationshi	o (Type, Print) 19b	. Mailin	g Address	(Street a	n <i>d Number</i>	or Rura	l Route Numbe	r, Cify or To	wn, State, Zip	2 @78	4
Baltimore, N	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e ance.	, ,	Pascual Vivar 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	20b. Place of Cometer Guad	Dispos		e of	Str		ate	20c. Location	Mary on-City or To La, Mex	wn, State	
Baltin	permit. P Departme Importar any injur		21. Signature Funeral Service Li							FUNER vd.Sil			-	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a	not ente	er the mode	of dying	, such as ca	ardiac o	r respiratory ar	rest,		Approxima Interval Be Onset and	tween
8760,	sate be executed obysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Find at Index 1997 Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of Due to (or a) (or a										
O. Box 6	a death certific he attending p led for use as	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pre Other (spe						Date of delive	*	Year
Δ.	w requires that the been signed by t should be detach	by	Part II. Other significant condition	s contributing to death but not resulting in	the un	derlying car	use giver	n in Part I.		23e. Did to	/*	ontribute to th	e cause of	
al Records,		Completed								24a. Was a autop perfor	sy	death?	osy findings apletion of a	available cause of
of Vital	ding Physician: Th. h. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital: 1 Inpatient 2 ER/Out	tpatient	3 🗆 DOA	Other	_		(Check only or ne 5 ☐ Resid		Other (Specify	At Sc	ene
Division o	ding I. After fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could no	tion - 2 - 0 0	308	5 M		at es 2 X No	, ,	8d. Describe h	of m	obt ve	30	
Div	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the		4 Homicide determine	building, etc. (Specify)	5/5	eet				7903	State	US R	لمحا	iber,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my knowledge aminer: On the basis of examination and and manner stated.	, death dor inv	occurred at astigation, in	t the time n my opi	, date and p nion, death	place, a occurre	nd due to the d d at the time, d	ause(s) and late and plac	manner as st e, and due to	ated, the cause(:	s)
	with com	Σ	29b. Signature and title of certifier	1 m P000	2		License C.M.				_	2, 20		
<u></u>	V		39 Name and address of person what Richard	ONICA-POLLAKIA	Type. P	Print) Penn	Stre	et, B	alti	Lmore,				
	Sta Registr		31. Date filed (Month, Day, Year) JAN 05	32. Figistrar's Signature	14	ode								

MICHAEL A. PARKER amend item# Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. 05-00331 State of Maryland / Department of Health and Mental Hygien 0/265 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 14, 2005 Michael Anthony Parker 12:16a ™ /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 825 VIRGINA AVENUE CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 08/03/1985 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) **Funeral** 1፟∭M 2□ F 213-13-0922 19 Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits in than "natural", or Items 23e or 28a-f show the Medical Examinar must be notified at MDAllegany Cumberland 1 Yes 2 □ No Director 10f. Zip Code 21502 10e. Street and Number 433 Bond Street 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23 ury or other traumatic event, the Medical Examinat must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: by White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Parker Porte Sharon Kay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon K. Parker / mother 433 Bond Street, Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ACremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Cumberland Crematory 01/15/2005 Cumberland, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Licensee 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician a Fentanyl Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No be detached for Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 IXYes 2□ No 24a. Was an certificate has autopsy performed? Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 1X Yes 2 □ No 2 ER/Outpatient 3 DOA After this 28b. Time of Fnchjury 27. Manner of Death 28a. Date of Injury FindMonth, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 1 ☐ Yes 2 No investigation 2 Accident 12:10 A hours after death uneral Director: 1/13/05 6

☐ Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 825 Virginia Ave Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Found at home Cumebrland 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) and title of certific JANUARY 14, 2005 OCME Name and address of person who completed cause of III Penn St., Baltimore MDQBOI State 2005 Registrar

	Hegistrar Decedent's Name (First, Middle, Last	State of Maryland / Dep 1-1 per mergand / Dep Ce		2. Date of Death		3. Time of Death
nysician	Paula	Ann Phillips		JAN.	8, 2005 Year	02 1 8 A ^M
ledical aminer	4a. Facility Name (If not institution, give		4b. City, Town, or Location of De	eath	4c. County of Death	
	27410 MECHANIC	SVILLE ROAD	MECHANICSVILL		ST.MARY	
	5. Social Security Number 6. Se	7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 H Months Days Hours M	in. (Month, Day, '		place (State or Foreign intry)
	253-59-3726 Usual Residence of Decedent			September	9,1981 Vi	irginia
	10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
cto	Maryland Saint Mar	ys	Hollywood			1 ☐ Yes 2 X No
Dire	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cou	intry?
Funeral Director	26005 Jones Wharf Ro		Was Decedent of Hispanic Origin?	(Specify Yes or No-	USA 14. Race - Amer	ican Indian.
팹	1 ☑ Never Married 2 ☐ Married	1 ☐ Yes 2 🔯 No	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	ierto Rican, etc.)	Black, White	
ģ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: Wh:	ite
Completed	15. Decedent's Ed (Specify only highest grad	ucation 16a. Dece de completed) (Give	edent's Usual Occupation o kind of work done during most of DO NOT use retired)	working	6b. Kind of Business/Ir	ndustry
g	Elementary/Secondary (0-12)	College (1-4or 5+)			D	
	17. Father's Name (First, Middle, Last)	, Rece	ptionist 18. Mother's i	Name (First, Middle, Mi	Doctor's Offi aiden Sumame)	ce
To Be	Paul Floyd Phillips		Bever'	ly Ann Justus		
	19a. Informant's Name/Relationship (7	ype, Print) 19b. Mail	ing Address (Street and Number or			ip Code)
	Paul Floyd Phillips /		5 Jones Wharf Road,	-	aryland 20636	
	20a. Method of Disposition 1 🖾 Burial 2 🗀 Cremation 3 🗀		matory or other place) J	Date 2	Oc. Location - City or T	own, State
	'4 □Donation 5 □Other (Specify	/		L3, 2005 C	layton, Georg	ia
	21. Signature of Funeral Service Licen	M M	 Name and Address of Facility [attingley-Gardiner] 	Funeral Home,	P.A.	
	23a. Part . Enter the disease, or comp	plications that caused the death. Do not en	.O. Box 270, Leonard			Approximate
	shock, or heart failure. List only of Immediate Cause (Final		Interval Between Onset and Death			
	disease or condition resulting in death)	a. Due to (or as a consequence of):	LIMRIES			
	Sequentially list conditions	b				
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a consequence of):				
хап	that initiated events resulting in death) Last	c				
ja		d				
ledic		u				
Physician/Medic	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of deliv	
Sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Onknown		Other (specify)		Month	Day Year
Ph)		ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
d by	•	,		1 ☐ Yes	s 212 No 3 Pro	bably 4 🗆 Unknown
lete				24a. Was an	24b. Were aut	opsy findings available
Completed				 autopsy perform 1 ✓ Yes 	prior to et	ompletion of cause of
O O	25. Was case referred to medical		26. Place of I	Death (Check only one		20140
To B	examiner? 1 XYes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursin	g Home 5 Residen	nce 6 XOther (Speci	ify) AT SCENE
	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) 28b. Time (Work?	28d. Describe how		struck a pol
cati	2 Accident investigation 3 Suicide 6 Could not be	01 -50 00 4-1-1			enicle whate	4 - TECH 4/4 1/34
iliti	4 Homicide determined	28e. Place of Injury - At home, farm, si building, etc. (Specify)	Roadway	Rd CitMeCha	micsville,	eghayigawil
Medical Certification;	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge, dea	-(F- M)	ace, and due to the cau	use(s) and manner as	stated.
dici		iner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death o	ccurred at the time, dat	te and place, and due	to the cause(s)
ž	29b. Signature and title of certifier	,	29c. License number O.C.M.E	29	d. Date signed (Month,	
1	// // /-	water mi	O.C.M.E		JAN. 8, 2	,000,
	Beitin	11/200 > 11/11				
	30. Name and address of person who	completed cause of death (Item 23a) (Type		NDD MARKET :	m 04604	
	BERT F. 1	TURON 111 PENN	Print) STREET, BALTIMO	DRE, MARYLAN	ND 21201	
national Medical Certification; To Be Comp	30. Name and address of person who of the state of the st	111 PENN 32 Registrar's Signature		DRE, MARYLAN	ND 21201	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar 1-6-05 Amena					and Mental Hyg	jiene	5 01267
~	Physici /Medic		Decedent's Name (First, Middle, La					2. Date of Deal Month January	th Day	Year 11:57 A.
	Examir		4a. Facility Name (If not institution, given 9203 Fowler La	ne			nham			e George's
	Funeral Director			Sex 7. A	Age (In yrs. last birthd 97 Yrs	Months Days		Min. Jan 22,	⁷ 1907	9. Birthplace (State or Foreign Country) Massachusetts
	th the Maryland or 28a-f show e rediffed at	Director	10a. State 10b. County Maryland Prince 10e. Street and Number	: George's	10c. City, Town of	I 10f. Zip Code	anham	1	0g. Citizen of W	·
9036	be filed within 72 hours after death with the Maryland tal Hygiene. od other than "natural", or items 23e or 28e-1 show event, the Medical Evantiner must be redified at	Funeral	9203 Fowler La 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	7 40			gin? (Specify Yes or No- n, Puerto Rican, etc.)	14. Race	SA - American Indian, k, White, etc. White
21215-0036	2 should be filed within 72 h and Mental Hygiene. Is marked other than "natu aumatic event, the Medical	Completed by	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 6th 17. Father's Name (First, Middle, Last	ade completed) College (1-4o	(G	cedent's Usual Occu ive kind of work done b. DO NOT use retire Teams	during moss ed) ter	t of working or's Name (First, Middle, N		vate
land	od it d))								
										State, Zip Code)
Baltimore,	Pa Int:		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3⅓ 1 □ Donation 5 □ Other (Special	(y)	cemetery, o	position (Name of prematory or other plane Ceme 22. Name and Addr	etery	jan10,2005	Fall FAll R	
Bal	permit. Departm Importa any inju		21. Signature of Puneral Service Lice	Road, Lanha	m MD 20	706				
8760,	American and hysician and the buriar-transit the bu	dical Examiner	23a. Panf. Enter the disease, or combodies of the control of the cause Enter Underlying Cause (Disease or injury that initiated events resulting in death)	a. Due to (or a	as a consequence of):	ry fo	art	failure	751,	Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 Fetal death at time of death	3 □Ectopic pregnand 5 □ Other (specify)	су		23d. Date Mont	o of delivery th Day Year
rds, P	quires that an signed b uld be deta	by	Part II. Other significant conditions	contributing to death	but not resulting in th	e underlying cause g	iven in Part I.			bute to the cause of death?
Vital Records,		e Completed	25. Was case referred to medical					24a. Was ai autops perform 1 Yes 2	y neg? de	fere autopsy findings available for to completion of cause of eath?
No spital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 PASTURE 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Injury at Work? M 1 Per 2 No Injury occurred 28d. Injury at Work? M 1 Per 2 No Injury occurred 28d. Injury at Work? M 1 Per 2 No Injury occurred 28d. Injury at Work? M 28d. Injury at Work?									d	
	Hospite 24 hours Funerei stely fille	edical Ce	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Examone)	nysician: To the bes miner: On the basis and manner:	of examination and/o	eath occurred at the t investigation, in my	ime, date an opinion, deal	d place, and due to the ca th occurred at the time, da	tuse(s) and maniate and place, an	ner as stated. nd due to the cause(s)
)	To the within 2 To the complete	Me	29b. Signature and the of certifier	2Mg	elly r	16 m	se number	257	9d. Date signed	(Month, Day, Year)
2	1		30. Name and address of person who Br. Edward Mos	Ley, 87∞	Central A	re, Landov	ær, M	d 20721		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 6 200	15 Regis	strar's Signature	ale				

State of Maryland / Department of Health and Mental Hygien 0 5 01268 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 11, 200^{Year} 2:33 Рм Martha Caroline Phillips /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caroline Caroline Nursing Home, Inc. Denton Hours Min. 8. Date of Birth (Month, Day, Ye) 7. Age (In yrs. last birthday) If Under 1 Year Months Days **Funeral** 9. Birthplace (State or Foreign 1 □ M 2/2 F Months Director Maryland 82 215-18-4153 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits rai', or items 23a or 28e-f shov Examiner must be notified at 1 ☐ Yes 2 No Maryland Caroline Greensboro Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of death 21639 Funeral 12051 Whites Lane America 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 ģ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 □ Divorced "natural" Caucasian Completed The Mudical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene Geriatrics Caregiver 11 HS Grad. permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other treumatic event. 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) Edna Moore George W. Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20720 item 2 12336 Quilt Patch Lane, Bowie, Maryland Richard L. Phillips Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 1/18/2005 Denton, Maryland Denton Cemetery 21. Signature of Funer I Service License 22. Name and Address of Facility
Moore Funeral Home, P.A. once 21629 jaudi 12 South Second Street, Denton, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** COTONAN resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to misclate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsecuanga of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death signed by the a 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records. certificate has been si irector, page 2 should l 1 Yes 2 No 3 Probably 4 Denknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2□ No 1 Yes 2 No 1 🗆 Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: Approximation Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₽No Hospital: မှ 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division 1 Natural 5 Pending investigation death. 1 □ Yes 2 □ No 2 Accident Director 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 3

Pircter, Leanard

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please 1			k Indelible Ink			_	10
		1 - For State Registrar	State of Ma	aryland / [Department of I Certificate of			71111	5 01269
0		Decedent's Name (First, Middle, Last))		Cortinoate of	Dealit	2. Date of Dea		3. Time of Death
Physici /Medic		Leonard	Eugene	Pinder	, Sr.	4	Janua	Jy ID 200	
Examin		4a. Facility Name (If not institution, give	street and number)	Fast	4b. City, Town,	or Location of Death		4c. County of De	ath
Funeral	_	5. Social Security Number 6. Sec	7. Ag	e (In yrs. last bir	thday) If Under 1 Year Months Days		8. Date of Birtl (Month, Day	h 9. B	irthplace (State or Foreign Country)
Director		217-30-7949 15 Usual Residence of Decedent	M 2□F	70	Yrs. Days		August		aryland
show		10a. State 10b. County		10c. City, Tow	n or Location				10d. Inside City Limits
8a-1s	Director	Maryland Talbot		Eas	ton				1 ☑ Yes 2 □ No
rs atter death with the Maryland I, or Itams 23a or 28a-f show Kaminer must be multiled at	Dire	10e. Street and Number 201 Federal Street	7 0	•	10f. Zip Code			10g. Citizen of What (United Sta	Country? ates of
death	Funeral		12. Was Decedent I		21601 13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe	cify Yes or No-	14. Race - An	nerica nerican Indian,
or Ita		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ X If Yes, Give	No	if Yes, specify Cub		Rican, etc.)		nite, etc.
hou ura	ed by	3 Widowed 4 Divorced	Year or Dates:	160	Decedent's Usual Occur			Specify: Caucas	
within 72 ene. than "nat	Completed	(Specify only highest grade Elementary/Secondary (0-12)			(Give kind of work done life. DO NOT use retire	pation a during most of workir ad)	ng	16b. Kind of Busines	s/Industry
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ibe fill ntal H ad oth	Be	17. Father's Name (First, Middle, Last)	_			18. Mother's Name	(First, Middle,	Maiden Sumame)	
should nd Me mark mark	To	Ernest Pin 19a. Informant's Name/Relationship (Ty		19b	. Mailing Address (Street		May Ch		Zin Code)
ges 1 and 2. Should be filed within 7. goes 1 and 2. Should be filed within 7. If I dealth and Mental Hygiene I if I fam 27 is markad othar than "n or othar traumatic avant, the Mottle		Ellen Bridge Pinde	er Wife					arvland 21	601
Pages 1 ient of He int: If itan		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R		20b. Place of cemeter	11 Federal S Disposition (Name of ry, crematory or other pla	ICe)	ate	20c. Location - City of	
t. Pa rtmen rtent:		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service License	m 1 1	Conco	ord Cemetery		2005 1	Nr Denton,	Maryland
permi Depa Impo any ir	ļ	Touch of	Pho	-NZ	Moore Fur	neral Home,	P.A.		24.422
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused	the death. Do r	not enter the mode of dying	Second Str ng, such as cardiac or	respiratory arr	enton, Mar	yland 21629 Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Conge	stive h	eart fail	me			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	2			0.1001
	er	Se ventially list conditions if any, leading to immediate	Due to (or as	consequence	of):	mal			weeks
be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
E 29. 00	=	resulting in death) Last	Due to (or as a	a consequence o	of):				
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Attending Physician: The law requires that the death certificate roteath. actor: After this certificate has been signed by the attending phys by the tuneral director, page 2 should be detached for use as the	M/W	200. Was decodorit pregnant	3c. If yes, outcome of		3 Ectopic pregnancy			23d. Date of de	elivery
ie deal the att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown		5 Other (specify)	у		Month	Day Year
that the ed by detacl		Part II. Other significant conditions con	tributing to death bu	it not resulting in	the underlying cause any	ven in Part I	23e. Did tot	bacco use contribute t	to the cause of death?
quires n sign ald be	ed by	Rheymatord	disea	se					Probably
law reas bee	Completed						24a. Was a		utopsy findings available
The	Com						autops perform	ned? death? 2 Solo 1 ☐ Ye	completion of cause of s 2 (NaNo
sician certiti rector,	Be	25. Was case referred to medical examiner?	ospital:		tradicat 25 pg. Oth	26. Place of Death			
g Physer this eral di	n: To	27. Manner of Death	28a. Date of Injur	y 28b. T	ime of 28c. Injur	4 Nursing Hom		once 6 Other (Special Control of the	ecify)
anding sath. or: Afte he tun	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Ir		rk? Yes 2 □ No			
or Att	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	ry - At home, far . (Specify)	rm, street, factory, office	28	Bf. Location (St. City or Town	reet and Number or R n, State)	lural Route Number,
spital lours a neral filled		29a. Certifier Certifying Phys	icien: To the best o	f my knowledge	, death occurred at the tin	me date and place ar	nd due to the ca	auco(s) and manner	o stated
To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certilicate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Exemination)	er: On the basis of and manner state	examination and	Vor investigation, in my o	opinion, death occurred	d at the time, da	ate and place, and du	e to the cause(s)
To t withi To t	≥	29b. Signature and title of certifier		-10-	29c. Licens		29	9d. Date signed (Mon	th, Day, Year)
		Danshim U	ungan	athan	mp D os	> 1147	JY	MUARY	10 2005
		30. Name and address of person who con Lakshmi Vaidyanath				aton Street	. East	on. Marvla	nd 21601
Stat		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	- 4	,	-,	FRAL Y LO	2.001
Registra	ir 🌡	JAN 13 2	2005	Euro D	(Spechi				

			1- State of Maryland / Department of Hea Certificate of Department of Hea		ıl Hygier Reg. 1	~ CUU."	01270
			1. Decedent's Name (First, Middle, Last)	2. Date	e of Death		3. Time of Death
ı	Physici /Medio		M 77'7 D 7 G	Moi		Day Year	0237 M
	Examir			ation of Death	- 4	4c. County of Dear	th
			Peninsula legional Medical Center Salishi	ord		Willow	
в	Funeral		1X M 2 ☐ F Months Days Ho	Under 24 Hrs. 8. Date lours Min. (Mo.	e of Birth onth, Day, Yea		hplace (State or Foreign ountry)
	Director		218-30-1114 75 Trs. Usual Residence of Decedent	Sept	ember 19	9, 1929 M	aryland
	yland		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	e Wa	ctor	Maryland Wicomico Parsonsburg				1 ☐ Yes 2 🔀 No
	or 28	Director	10e. Street and Number 10f. Zip Code		10g. (Citizen of What Co	ountry?
	ath w					USA	
	ter de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispan If Yes, specify Cuban, Me	nic Origin? (Specify Yes lexican, Puerto Rican, e	s or No- etc.)	14. Race - Ame Black, White	
36	hours after death with the Maryland turel', or items 23a or 28e-f show al Exercities must be notified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Yes 2 ☒ No Sp Year or Dates:	pecify:		Specify:	
21215-0036	72 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation)	16b.	Kind of Business/	hite Industry
218	within 7 ene. than "n	Completed	(Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	g most of working			,
2	filed wi Hygien other th	Con	7 Farmer			Agricul	ture
and	be fill d off	Be	17. Father's Name (First, Middle, Last)	Mother's Name (First, i	Middle, Maide	en Surname)	
Z	2 should be and Mental is marked (eumatic ev	J.		Beulah		Tay	
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hygiene. If item 27 is marked other than "neturel; or items 23a or 28e-f show or other treumatic event, If a Madical Examination as I be notified at		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and N				
	Health Health tem 27 other tr		Susan Perdue (daughter) 31696 Hideaway 1 20a. Method of Disposition 20b. Place of Disposition (Name of	Drive, Pars		rg, Mary. Location - City or	
OLL	Pages nent of l ont: If it		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	Townson O		,	
Baltimore,	그 된 원 중		CLEGIE IBIDLY GEGEB	Facility 17	те бы	oron, Ma	ryland
Ö	Depa Impo		21. Signature of Funeral Service Licensee Color Color Color Color	l Road. Sa	Process Lichur	Sional As	ssociation and 21804
			23a. Part1. Enter the disease, or complications/that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line.	ich as cardiac or respira	atory arrest,	y/ Maryic	Approximate Interval Between
	Physician -		Immediate Cause (Final disease or condition	F 0 D			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	100			
	Examine:	_	Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):				
	ted nsit	Examiner	Due to (or as a consequence of): cause. Enter Underving Cause (Disease or injury				
<u>,</u>	execun n and ial-tra	Exar	that initiated events c. Due to (or as a consequence of):				
68760,	ificate be executed g physician and as the burial-transit	edicai					
_							
Вох	death certif e attending od for use a	an/N	IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of deli	,
0	00	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Unknown			Month	Day Year
<u>α</u>	The law requires that the death cer te has been signed by the attendir age 2 should be detached for use	by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in I	Dott 1 220	Didtahaaa		the cause of death?
ds,	signe d be	d by	Cerebrousalor Deciber	Faiti. 236			bably 4 Unknown
cor	v requ	ete	11 1 1 2 2 1 2 1	24-	a. Was an		
Be	he lav e has	Completed	Myx cholesienen	244	autopsy performed?	prior to c death?	opsy findings available ompletion of cause of
tal		O	25. Was case referred to medical	1 ☐ Place of Death Check	Yes 2□N	o 1 □ Yes	2 No
<u> </u>	Physicien: r this certifice ral director, p	lo B	examiner? 1 Yes 2 No	□ Nursing Home 5□		6 □Other (Spec	ify)
0	ng Ph Iter th neral	Ju: T			scribe how inju		.37
Sio	ttendir death. stor: Al / the fu	catic	2 Accident investigation M 1 Yes	2 🗆 No			
Division of Vital Records,	l or Atl after d Direct I in by	Certification:	3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ation (Street a or Town, Stat	and Number or Rui te)	ral Route Number,
	pitel			eta and alam and dur	4-46		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, da (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	n, death occurred at the	to the cause(s time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the complete compl	Me	29b. Signature and title of certifier 29c. License num	nber	29d. Da	ate signed (Month	Day, Year)
) W	1150		1/3/4	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	./		1	
			30. Name and address of person who completed cause of death (Item 23a) Type, Print) 5. Hearne, M.O. / Old Milfard 31. SAU/32 31. Date filed (Month, Day, Year) JAN 0 5 2005 32. Positivar's Signature	bung me	7		
	Sta Registra		31. Date filed (Month, Day, Year) JAN 0 5 2005 32. Registrar's Signature	/			
	riegisii	AT .	DAIL A G TOO? DEVENT TO PROPERTY				

Physic		1 - State Registrar 1. Decedent's Name (First, Middle,		ertificate of Death		3. No. 2005 012
			Goldsborough Pritch	o++	2. Date of Death Month January	Day Year
/Medi Examir		4a. Facility Name (If not institution, 320 Muir Street		4b. City, Town, or Location of Deat Cambridge		01, 2005 14:25 4c. County of Death Dorchester
Funeral Director		5. Social Security Number 213–22–5682 Usual Residence of Decedent	6. Sex 1 ⊠ M 2□F 7. Age (In yrs. last birthda) 78 Yrs.	y) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		
-f show	tor	10a. State 10b. County	10c. City, Town or I	Location Cambridge		10d. Inside City 1 ⊠ Yes 2
3e or 28e at ke ncti	al Direc	10e. Street and Number 320 Muir St.		10f. Zip Code 21613	10	g. Citizen of What Country? USA
rel', or Items 23e or 28e-f show Exercipet in val ke notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
ane. Ihen "netu	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 7	Education grade completed) College (1-4or 5+) 16a. Dec (Giv life.)	edent's Usual Occupation re kind of work done during most of wor DO NOT use retired) deliveryman	rking	newspaper
and Mental Hygle is marked other l eumatic event, II	To Be C	17. Father's Name (First, Middle, L Freeland Ebern			me (First, Middle, Ma e Mills	aiden Sumame)
lealth and m 27 is mu her treum		19a. Informant's Name/Relationshi Mary Catherine N	likoden daughter 21	ling Address (Street and Number or Ru 7 Brentwood Rd., F	airless H	ill, PA 19030
Department of Health a Importent: If item 27 is any injury or other tre once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp. 21. Signature of Funeral Service)	Salisbury		3/05	Salisbury, MD eral Home P.A.
0 5 2 9		John Line Ja	omplications that caused the death. Do not ex	700 Locust St., Ca		
aminer			Due to (or as a consequence of):	_ Condivascul		
anding physician and use as the burial-transit	ical Exa	Sequentially list conditions. Any Jacob Immediate Cause. Enter Undertyling Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery
gned by the attending physician and be detached for use as the burial-transit	by Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Yea
been signed by the attending physician and should be detached for use as the burlat-transit	Completed by Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition	Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I.	23e. Did tobac 1 Yes 24a. Was an autopsy performe	23d. Date of delivery Month Day Yea co use contribute to the cause of deat 2 \(\sum \) No 3 Probably 4 \(\sum \) Unk 24b. Were autopsy findings ava prior to completion of caus dayath?
h. After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the buriat-transit	To Be Completed by Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I. 26. Place of Dea	23e. Did tobac 1 □ Yes 24a. Was an autopsy	23d. Date of delivery Month Day Yea 20 No 3 Probably 4 Unk 24b. Were autopsy findings avaption to completion of cause death? 10 Yes 2 No 24b. Were autopsy findings avaption to completion of cause death?
iter death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification: To Be Completed by Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of): b. Due to [or as a consequence of]: c. Due to (or as a consequence of]: d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown s contributing to death but not resulting in the live of the line	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I. 26. Place of Dea ent 3□ DOA of 28c. Injury at Work? M 1 □ Yes 2 □ No treet, factory, office	23e. Did tobac 1 Yes 24a. Was an autopsy performe Yes 2 th (Check only one) ome 5 Residence 28d. Describe how 28f. Location (Stree	23d. Date of delivery Month Day Yea 2 No 3 Probably 4 Unk 24b. Were autopsy findings ava prior to completion of caus d? No 1 Yes 2 No 24b. Were autopsy findings ava prior to completion of caus dath? 1 Yes 2 No 24c. WXOther (Specify) SCENE injury occurred
iter death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	Certification: To Be Completed by Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I. 26. Place of Dea ent 3□ DOA of 28c. Injury at Work? M 1 □ Yes 2 □ No treet, factory, office	23e. Did tobac 1 Yes 24a. Was an autopsy performe Yes 2 th (Check only one) ome 5 Residence 28d. Describe how 28f. Location (Stree	23d. Date of delivery Month Day Yea 2 No 3 Probably 4 Unk 24b. Were autopsy findings ava prior to completion of caus d? No 1 Yes 2 No 24b. Were autopsy findings ava prior to completion of caus dath? 1 Yes 2 No 24c. WXOther (Specify) SCENE injury occurred
Itler this certificate has been signed by the attending physician and unrari director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1	□Ectopic pregnancy □ Other (specify) underlying cause given in Part I. 26. Place of Dea ent 3□ DOA of 28c. Injury at Work? M 1 □ Yes 2 □ No treet, factory, office	23e. Did tobact 1 Yes 24a. Was an autopsy performe 1 Yes 2 th (Check only one) ome 5 Residence 28d. Describe how 28f. Location (Street City or Town, 5	23d. Date of delivery Month Day Yea 2 No 3 Probably 4 Unk 24b. Were autopsy findings ava prior to completion of caus d? No 1 Yes 2 No 24b. Were autopsy findings ava prior to completion of caus dath? 1 Yes 2 No 24c. WXOther (Specify) SCENE injury occurred

			1 - For State Registrar		artment of Health and M rtificate of Death		ene	01272
	Physici	an	Decedent's Name (First, Middle, Last)	_		2. Date of Death Month	Day Year	3. Time of Death
	/Media	cal	Caroline Gertrude 4a. Facility Name (If not institution, give street ar		4b. City, Town, or Location of Death	January January		
1	Examin	ier	Loyalton Assisted Liv		Hagerstown		4c. County of Dea Washingt	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		thplace (State or Foreign
	Director		577-01-1410 1 □ M 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	80 115.		January		ashington DC
	shov	ō	10a. State 10b. County	10c. City, Town or Lo	-			10d. Inside City Limits 1 ☐ Yes 2 M No
	28a-f	Director	Maryland Washington 10e. Street and Number	Hager	Stown 10f. Zip Code	100	. Citizen of What Co	
	3a or		20809 Mt. Aetna Road		21742	-	United St	
	death	Funeral	11 Marital Status 12. Was	Decedent Ever in U.S. 13. \	Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto I		14. Race - Ame	erican Indian,
9800	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show edicul Examirer must be notified at	by	If Ye	/on CRINO	1 Yes 2 No Specify:	rican, etc.)	Specify: W	hite
Maryland 21215-0036	표 교육	Completed	15. Decedent's Education (Specify only highest grade completed in the complete state of	ited) (Give	dent's Usual Occupation kind of work done during most of workin DO NOT use retired)	ng 16	b. Kind of Business	/Industry
121			12		Department Manager		Departmen	t Store
and	a d d a s	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name		niden Sumame)	
Ž	2 should be and Mental is marked is marked is	ဥ	William Richardson 19a. Informant's Name/Relationship (Type, Print) 19h Mailir	Fsther Manage Address (Street and Number or Rura		City or Tourn State	7in Codo)
	nd 2 s lith ar 27 is r trau		Carolyn A. Detrow		9 Mt. Aetna Road H			
re,	ges 1 and 2 should it of Health and Men if itam 27 is marke or othar traumatic	1	20a. Method of Disposition	20b. Place of Dispo			c. Location - City or	
E	Pages nent of I int: If its		1 Surial 2 Cremation 3 Removal '4 Donation 5 Other (Specify)	rom State	n Cemetery 1-12-	2005 н	agerstown	Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee		Name and Address of Facility Dou 331 Eastern Blvd.	glas A.	Fiery Fun	eral Home
	5.00		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause	hat caused the death. Do not ent-				Approximate Interval Between
	Physician	0 1	Immediate Cause (Final disease or condition	Adenocarcinon	ng of unknown	Drie	nar.	Onset and Death
	/Medical Examiner		resulting in death)	e to (or as a consequence of):			ઠે	
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	nsit	Examine	cause. Enter Underlying Cause (Disease or injury	a to for as a consequence of				
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8760,	cate be executed obysicien and the burial-transit		d					
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Вох	death certific e attending p id for use as i	an/N		i, outcome of pregnancy ive birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of del	,
о. В	0 0 0	sici	1 Ves 2 No		Other (specify)		Month	Day Year
Q _	that the de led by the s detached f		Part II. Other significant conditions contributing	to death but not resulting in the ur	aderiving cause given in Part I	23a Did tohac	aco use contributo to	the cause of death?
ds,	w requires that the sbeen signed by the should be detached	d by		to count but not resulting in the un	conying cause given in Fait i.		_	obably 4 🕮 nknown
Vital Record	w requ been shoul	Completed				24a. Was an		
Re	e ta	dmo				autopsy performed	d? prior to death?	topsy findings available completion of cause of
ta		0	25. Was case referred to medical		26. Place of Death	(Check only one)	Mo 1 □ Yes	2 No
<u>></u>	χ ω β	ToB	examiner? 1 Tes 2 No Hospital:	1 Inpatient 2 ER/Outpatien	- Other		e 6 □Other (Spec	cifv)
n of	ng Ph Iter th		27. Manner of Death 1 Natural 5 Pending 28a. €	Date of Injury Month, Day Year) 28b. Time of Injury		8d. Describe how		
Sio	Attanding r death. sctor: After by the funer	catic	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
Division	l or Att after d Diract I in by (Certification;	3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office 2	8f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
	pital ours a aral C		200 Carifier 15 Camit is a	Abo book of the format of the second	<u></u>			
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edicai	Check only 2 Medical Examiner: On t	o the best of my knowledge, death he basis of examin <i>a</i> tion and/or inv manner stated.	occurred at the time, date and place, and vestigation, in my opinion, death occurred	nd due to the caus d at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To tha complet	Med	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month	ı, Day, Year)
)	- > - 0		1		D0054451	_		
	The second secon		30. Name and address of person who completed	cause of death (Item 23a) (Type, I		- 1	1	2005 Varyland
9	4-4		Of the second	911 Jefferson	Blud.	Smithsl	0315 M	aryland
	Sta Registra	1.67	31. Date filed (Month AN 11 2005	2. Rigistrar's Signature	rede		,,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5,2005 7:00p Harriett K. Richardson January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner E1kton <u> Union Hospital</u> If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 M 2 F Director 87 20,1917 161-05-0308 September PA Usual Residence of Decedent death with the Marylend 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits orient: if item 27 is marked other than "natural", or items 23a or 28e-f show injury or other treumstic event, it a Micilian Examinar must be notified at 1 ☐¥es 2 ☐ No Director MD Cecil E1kton 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 310 Skipjack Court Apt. 21921 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or iter any injury or other treumetic event, it a Medical Examination. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Nanette Manufact. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Knipe Anna May Selah 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Musser/Daughter Tree Lane, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery January 8,2005 E1kton, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Andrew G. Gee Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21921 Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? res 2 No 2 No 1 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 1 ☑ Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S.S. SACHDEUMD, Il SNOWLK SF, SU se of death (Item 23a) (Type, Print) USNorth St., Suite 3B, Elhton MD 21921 31. Date filed (Month, Day, Year)

JAN 7 -32/Aegistrar's Signature State Registrar

			State of Maryland / Department of Health and N 1- State Amend Item 29d per Dr., G840 02/115/2005 death	Mental Hyg	giene 005	01274
			1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ith	3. Time of Death
	Physici /Medio		Eleanora M. Kidyley	Jan.	4 2005	3:06 P M
	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	1	4c. County of Death	10
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Monigor	nery Co. lace (State or Foreign
	Funeral Director		578.46-4008 1 M 2 7 / Yrs. Months Days Hours Min.	(Month, Day	, Year) Coun	ington DC
	D		Usual Residence of Decedent	Triprit !	, , , , , , , , , , , , , , , , , , , ,	/
	arylar ahow	<u>_</u>	DC 10b. County 10c. City, Town or Location Washington D. C	P	1	0d. Inside City Limits 1 → Yes 2 → No
	Ne M	ectc		,		
	with with	Ö	3940 First Street, S.W. 20032		10g. Citizen of What Cour	itry ?
	within 72 hours after death with the Maryland ene. than 'natural', or Items 23a or 28a-f ahow ta Madical Examirer mast be notified at	Funeral Director		pecify Yes or No-	14. Race - Americ	an Indian,
9	after o	Fur	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)		etc.
21215-0036	ral', c	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		Specify: 13	lack
15-	"natu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Business/Ind	dustry
12	within ene. than than	duc	Elementary/Secondary (0-12) College (1-4or5+) 6 Vrs Teacher		DC Public	School
	illed Hygi other	Be C		ne (First, Middle,	Maiden Surname)	
/lar	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, It e M.	To B	Herman Marshall Mar	4 Coi	1bert	
Maryland			19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run 3910 Southern	ral Route Numbe	r, City or Town, State, Zip	Code)
	1 and Health em 27 ither tr		Sherene Ridgley (Paugher) Washington D.C	7	20	
altimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		cometent crematory or other place)	1.	20c. Location - City or To	
Ħ.	iit. Partmer artmer ortant injury		'4 □Donation 5 □Other (Specify) Cedas H,// □ 21. Signay of Funeral Service Licensee 22. Name and Address of Facility	- 2005	Suitland	+ Joia.
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н	Examiner		Sequentially list conditions, b.			
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	<u> </u>		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Injury Work?	28d. Describe h	low injury occurred	
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Division	after death after death Director: I in by the	Certification:	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tow	Street and Number or Rura m, State)	Il Houte Number,
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	rred at the time, o	date and place, and due to	the cause(s)
	To ti Withi To ti comp	M	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month,	
	1		9 D45660		January 4,20	U3
K	4		30. Name and address of person who completed cause of Seath Wem 23a) (Type, Print)	Ben	io MD	20 71-
	* Sta	ate.	31 Date filed (Month Day Year) 42 Benistrar's Signature			
	Regist		JAN 0 7 2005 Keen & Species			

		Unpend item/23a 1- State Registrar			Certificate of	Death		Reg. No	/ "	01275
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/Media	cal	Inger Helland Ro			4 07 7		Januar			
Examir	ner	4a. Facility Name (If not institution, g 18108 Copps Hill			4b. City, Town,				County of D	
Funeral			Sex 7. Ag	e (In yrs. last	Montgome birthday) If Under 1 Year	If Under 24	Hrs. 8. Date of B	irth	ontgom	ery Birthplace <i>(State or Foreign</i> Country)
Director		340-26-1643	1□M 2X F	78	Yrs. Months Days	Hours	JAN 6,	192	7 No	rway
A T		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Location					10d. Inside City Limits
de per	to	Maryland Montgom	ery	Monte	gomery Villag	ge				1 ☐ Yes 2 🖔 No
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturat", or Items 23s or 28s-f show amount in items in the mailting an annual tennelling at an annual tennelling at an annual.	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What	Country?
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lter in	une	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decedent of If Yes, specify Cut	Hispanic Origin ban, Mexican, P	(Specify Yes or Nuerto Rican, etc.)	0-	14. Race - A Black, W	merican Indian, hite, etc.
1, or	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 🛣 Divorced	1 ☐ Yes 2 🛣 I If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🖾 No	Specify:			Specify:	white
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othe		20a. Method of Disposition		20b. Place	of Disposition (Name of tery, crematory or other pla		nuary 13	20c 1		or Town, State
20		1 ☐ Burial 2 🌠 Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		1	peake Cremat		2005		tsville	. MD
any inj		21. Signature of Funeral Service Lic	11		22. Name and Address Thibadeau	ess of Facility	ry Servi	- I	- Δ	20910
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Physici /Medic		Natalie	Р.	Repett						7 MO	nth		Year	15:10 M
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vent, the M	Be	17. Father's Name	(First, Middle, Last)						18. Mother's Na	ıme (First,	Middle, M	aiden Suman	10)	
atic	2	Adam	Pilewicz							nina		gowski		
any injury or other traumatic event			Name/Relationship											^{c Code)} 20886 Md. 20866
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d in by	Certification;	4 Homicide	determined	28e. Place of building,	etc. (Speci	ily)	reet, lac	tory, onice			ity or Town		00, 0, 110,	arriodio Nambor,
completely filled in by the fu	edical C	29a. Certifier (Check only one)	1 Certifying Pl	hysician: To the be miner: On the basis and manner	s of examina	owledge, dea ation and/or in	th occurr ovestigat	red at the tir	ne, date and pla pinion, death oc	ce, and du	ue to the ca he time, da	use(s) and m ite and place,	anner as and due	stated. to the cause(s)
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2		10	A.A	-				N	(1817		3	Januar	y 7	2005
		30. Name and ac	idress of person who	completed cause of	of death (Ite	m 23a) (Type	, Print)	1	5 0 1 1				1	
		5.	Michae	1 Charac	cholo	· 4 9	100	Medi	al Cente	r Day	re Ro	ckville	MD	2005
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		•	For State Registrar	State of M	Maryland / De <i>C</i>	partment of e <i>rtificate o</i>			giene 005	01277
			Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
Н	Physicia /Medic		MARY FLORENCE	ROBEY	Z			JANUA:	Day Year RY 8, 200	5 7:45P ^M
	Examin		4a. Facility Name (If not institution, give s	treet and numbe	er)	4b. City, Town	, or Location of Dea	th	4c. County of Dea	
		•	ABBEY MANOR			_	PLATA		CHARL	
	Funeral		5. Social Security Number 6. Sex	м XIX F 7	Age (In yrs. last birthda 82 Yrs.	y) If Under 1 Year Months Day		. (Month, Da	th y, Year) 9. Bir Co	thplace (State or Foreign
Н	Director		073-22-9456	1	02			JAN. I	0,1922 MA	RYLAND
	yland	Ì	10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mar e-f sl	ctor	MARYLAND CHAF	RLES		LA PL	ATA			1X Yes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code	9		10g. Citizen of What Co	ountry?
	ath w	rai	123 MORRIS DRIVE				0646		U.S	
	er dei	Funerai		12. Was Decede Armed Force	nt Ever in U.S. 1	 Was Decedent of If Yes, specify Co 	f Hispanic Origin? (S uban, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race - Ame Black, Whit	
36	rs aft	by F	1 Never Married 2 Married 3X X Vidowed 4 Divorced	1 ☐ Yes 2∑ If Yes, Give Year or Date:		1 ☐ Yes 🏋	io Specify:		Specify: W	HITE
212#5-0036	within 72 hours after death with the Maryland ane. then "neturel", or Items 23s or 28e-f show in Medical Examer most be collified at	ted	15. Decedent's Educ	ation	16a. De	cedent's Usual Occ	cupation		16b. Kind of Business	
275	thin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4c	life	ve kind of work dor . DO NOT use reti	ne during most of wo ired)	rking	U.S. GOV	
7	filed wit Hygiene other the	Соп	12			GET ANA				AGRICULTUR
nd	be file d oth even	Be	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame)	
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Mai	OI 10 - B		JAMES R. ROBEY						er, City or Town, State,	
Ō,	1 and 2 Health tem 27 other tr		20a, Method of Disposition	UK30	20b. Place of Dis	position (Name of	256, FAU	Date Date	MARYLAND 20c. Location - City or	20632 Town, State
ē	Pages nent of int: If it		XIXBurial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta T	RINITY M	rematory or other p EMORIAL		-11-05	WALDORF	, MARYLAND
Baltimore, Maryland	그 된 원 중		21. Signature of Funeral Service License		M00479	22. Name and Add	fress of Facility			THANTBAND
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			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caus	sed the death. Do not	enter the mode of d	lying, such as cardia	c or respiratory a		Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):					2 414/
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8760,	cate be executed physician and the burial-transit	dicai								
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Вох	eath certif attending for use a	an/N	1F FEMALE: 23b. Was decedent pregnant in the past 12 mgnths?	3c. If yes, outcor 1 Live birth		3 □Ectopic pregnar	ncy		23d. Date of del	ivery Day Year
O.	ie dea the at	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant 9□Unknowr		5 Other (specify)			MOUTH	Day real
P.O.	that the death ned by the atter detached for u	Ph)	Part II. Other significant conditions con	tributing to death	n but not resulting in the	underlying cause	given in Part I.	23e. Did to	obacco use contribute to	the cause of death?
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sio	Attending ir death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				☐ Yes 2 ☐ No			
Division of	or At after of Direct in by	Certification;	4 Homicide determined		Injury - At home, farm, etc. (Specify)	street, factory, offic	20	City or Tov	Street and Number or Ru vn, State)	ıral Houte Number,
	spitel ours sure serel filled		29a. Certifier 1 Certifying Phys	ician: To the be	st of my knowledge de	ath occurred at the	time, date and place	e, and due to the	cause(s) and manner as	stated
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical			s of examination and/or				date and place, and due	
	To the within To the comp	Me	29b. Signature and title of certifier	0		29c. Lice	ense number		29d. Date signed (Mont	h, Day, Year)
)	•		Kuhl 21			D-48	8119		TANUARY 9,	2005
	X		30. Name and address of person who co							
			RICHARD E. BRA 31. Date filed (Month, Day, Year)	NSDORF	MD 120 strar's Signature	/O OLD]	LINE CEN	TER WA	LDORF MD	2060
	Sta Registr		JAN 1 9 2005	257	as As As	344				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year Frances Louise STOTELMYER 31104 ಎಯರ aurea /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth Jan. 27, 1930 Mary I and 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 □ M 2 🖾 F 74 Yrs. 216-22-9054 Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at Washington Maryland Hagerstown Director tXXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 79 Madison Avenue 21740 Items 23a U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 □ Yes 2 图 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 ō white 1 ☐ Yes 2 ☒ No Specify: Specify: 3 Nidowed 4 Divorced "naturel" 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7. th and Mental Hygiene. 7 is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 0 - 12Ò homemaker her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Whorton ဂ္ Lena P. Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is eny injury or other treu Terry L. Stotelmyer, Sr. -son 10070 Garis Shop Road, Hagerstown, Maryland 21740 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 January 11, 1 Burial 2 □ Cremation 3 □ Removal from State Rose Hill Cemeterv ^ 4 □ Donation 5 □ Other (Specify) 2005 Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 5 East Wilson Elvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician con the seuic yeary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 | No 2 No 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۲ 2 No 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred After Injury at Work? 1 Matural Injury 5 Pending after death. 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel I 29a. Certifier Lightifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State Registrar ABDUL

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32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year)

		1 - For State Registrar	State of Mary	land / Dep		lealth and	Mental Hygi	ene g. No.2005	01280
Physic	ian	1. Decedent's Name (First, Middle	Stale.	/			2. Date of Death		3. Time of Death
/Medi Exami		4a. Facility Name (If not institution UNIV. OF MD		Y	4b. City, Town, or	Location of Deat	h	4c. County of Death	7:17 PM
Funeral Director		5. Social Security Number 218-24-1703	6. Sex 7. Age (In	yrs. last birthday) 75 Yrs.		If Under 24 Hrs Hours Min.		Year) 9. Birthp Cour 1929 Mary	lace (State or Foreign try) / Land
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland be partment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County	ring Road 12. Was Decedent Ever Armed Forces? 1 Yes 2 YUNO Yes or Dates: 1's Education College (1-4or 5+) Last) Y ROW land hip (Type, Print) Ley - Son 20 College (1-4or State) 3 Removal from State College (1-4or State)	16a. Dece (Give life.) 19b. Mailii 1503 0b. Place of Dispocemetery, creen lawn G death. Do not ent	Williams 10f. Zip Code 2 Was Decedent of H If Yes, specify Cuba 1 Yes XXNo dent's Usual Occupion kind of work done of DO NOT use retired Fini again the specific of the composition (Name of Sosition (Name of Mem. Par	ispanic Origin? (Sn., Mexican, Puerla Specify: ation during most of work the share of the share	pecify Yes or No- o Rican, etc.) Trking The (First, Middle, M The Violation of the paral Route Number, P.A. The St. Williams, P.A. The St. Williams, P.A. The St. Williams or respiratory arrespiratory arresp	g. Citizen of What Cour USA 14. Race - Americ Black, White, Specify: Wh 6b. Kind of Business/Inc eather Proceedings of Town, State, Zip In Sport, Mary Oc. Location - City or Town Il iamsport, Il iamsport,	Od. Inside City Limits 1 Yes 2 X No htty? an Indian, etc. nite dustry cessing Code) Land 21795 wn, State Maryland MU 21795 Approximate Interval Between Onset and Death
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	b. Due to (or as a cord. Due to (or as a cord. Due to (or as a cord.) 23c. If yes, outcome of produce time and the second of	egnancy Fetal death 3[□Ectopic pregnancy	um 150	hema In	23d. Date of delive	ry Day Year
e law requires that the has been signed by the	ompieted by Phy	9 ☐ Unknown Part II. Other significant condition		t resulting in the u	nderlying cause give	en in Part I.	1 ☐ Yes 24a. Was an autopsy	24b. Were autop	e cause of death? ably 4 Unknown by findings available apletion of cause of
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Physicia this cert	To B	examiner? 1 res 2 No	Hospital:	2 ER/Outpatier	nt 3 DOA Othe	-	th (Check only one) Iome 5 ☐ Residen	ice 6 Other (Specify	·)
fter ner	Certification;	27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	gation	28b. Time o Injury	Work		28d. Describe how		,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		3 Suicide 6 Could i determ	building, elc. (Sp	oecify)			City or Town,		
To the Hospital or within 24 hours after To the Funeral Discompletely filled in	ledical	one) 2 Medical	g Physicien: To the best of my Exeminer: On the basis of examiner stated.	knowledge, death mination and/or in	vestigation, in my op	inion, death occu	rred at the time, dat	use(s) and manner as st e and place, and due to	ated. the cause(s)
with To I	Σ	29b. Signature and title of confiden	Milh	MD	29c. License			d. Date signed (Month, L) $01/05/2005$	
14-E		30. Name and address of person	who completed cause of death	(Item 23a) (Type,	Print)	of M	D Med	Oilos/2005 Center	
St Regist	ate rar	31. Date filed (Month Ray Year)	7 2005 32. Bigistrar's S	Signature 4.	seks				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JANUARY VIRGINIA V. SLOCUM 11:50PM 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7387 SOLITUDE RD. ST. MICHAELS TALBOT 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, OCT 18 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 21XF Min. NEW YORK 67 Yrs. Director 131-28-5649 Usual Residence of Decedent Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director TALBOT ST. MICHAELS 10e. Street and Number 10g. Citizen of What Country? 5 7387 SOLITUDE ROAD 21663 Items 23a Completed by Funeral USA should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ WHITE 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 REGISTERED NURSE HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OLIVER VANNOSTRAND VIRGINIA DUNLOP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an ent: If item 27 Is I CHARLES F. WIEDER JR./SON 7375 SOLITUDE LN, ST. MICHAELS, MD 21663 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. `4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 01-06-2005 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM 1 200 S. HARRISON ST EASTON, MD MERCEROL JeHN 13. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death LOBE mmediate Cause (Final ASTRO Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to in red later underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Neknown director, page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death Check on one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After ! 1 Natural 2 Accident Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2005 156741

State Registrar

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Amended.	4a.r	er	M.F., TCHD, 01/07/0	State of Mary	land / Dep	artment of h	Health and M	lental Hyg	giene.	
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	uneral		5. Social Security Number 6. S	XIM 2 IF	yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Day MAY 30	h 9. Bi	irthplace (State or Foreign Country)
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arylan	show	_	10a. State 10b. County	10	c. City, Town or Lo					10d. Inside City Limits
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ட் ந	em 27 thar t		SHAWN N. SUEHLE 20a. Method of Disposition		59 N . 20b. Place of Dispo		The second second	PHILAD]	ELPHIA, PA 20c. Location - City o	
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HOS HOS	na Fur cletely	ledical	(Check only 2 Medical Examone)	niner: On the basis of exa and manner stated	amination and/or in	vestigation, in my o	opinion, death occurre	ed at the time,	date and place, and du	e to the cause(s)
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			(and	1) /Cop	wh	My po	044282	_	1/04/0	5
			30. Name and address of person who	completed cause of death	n (item 23a) (Type, M.) 44	18 Buche	lons pt	Rd O	1/04/0	MD 2/1.54
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Physician /Medica	n	 Decedent's Name (First, Middle, Last) 		R. Steck	2		2. Date of Death Month		3. Time of Death
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Funeral Director		Doctor's Community 5. Social Security Number 6. Sev. 219-80-1291		yrs. last birthday) 43 44 Yrs.	Lan If Under 1 Year Months Days		8. Date of Birth (Month, Day, 1) April 29		e George's Birthplace (State or Foreig Country) Maryland
MO TI	-	Usual Residence of Decedent 10a. State 10b. County	10	oc. City, Town or Lo	cation			7 2704	10d. Inside City Limit
Sa-f sh Lifted	Director	Maryland Prince G	eorge's		Greenbel	t			1 Z Yes 2 □ N
Sa or 2		10e. Street and Number 8483 Greenbelt	Road #T-2		10f. Zip Code 2077	0	10	g. Citizen of Wha	•
	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hi f Yes, specify Cubar 1 ☐ Yes 2 🛣 No	spanic Origin? (Spen, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc. White
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27 is		Albina R. Steck		16 1	exington	Drive, H	anover,	PA 17331	
ant: if	-	20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ R 1 ☐ Donation ☐ Other (Specify)	emoval from State	20b. Place of Dispo cemetery, cren Chesapeal	sition (Name of natory or other place Ke Cremate	ory 1/5/2	ate 20	oc. Location - City eltsvill	e, MD
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24 hours atter death selenges by Funerel Director: etely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm, stri Specify)	eet, factory, office	2	8f. Location (Stre City or Town,	eet and Number o State)	r Rural Route Number,
Funer Funer ely fill	ledicai (29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Exami	sician: To the best of m ner: On the basis of exa and manner stated	amination and/or inv	occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	nd due to the cau id at the time, dat	use(s) and manne e and place, and	r as stated. due to the cause(s)
within 2 To the complet	Me	29b. Signature and titled certifier	MD		29c. License	number 5844	6	d. Date signed (M	1
6)	9	30. Name and odress of terson who co	empleded gause of death	n (Item 23a) (Type	Print) \$ 600	d Luck	Rd. M	202	12005

STECKD

State of Maryland / Department of Health and Mental Hygien [] [] 5 01284 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Vear Howard Robert Shocklev 7:45 A M January 2005 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caroline Nursing Home Denton Caroline If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Scountry)
July 21 1913 Delaware 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 218-20-5670 91 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rel', or iteme 23a or 28a-f ehov Examiner must be notified at 1 X Yes 2 No Directo Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "naturel", or Iteme 23a 520 Kerr Ave. 21629 Completed by Funeral USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 XWidowed 4 ☐ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within to Department of Health and Mental Hygiens Important: If I ten 27 is marked other than "n any Injury or other traumatic avent. Elementary/Secondary (0-12) Cotlege (1-4or 5+) 06 business owner feed, grain, trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Edgar Shockley 2 Sadie Hill Shockley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Carolyn Franklin/ daughter 15 Oceanaire Drive Rancho Palos Verdes, CA 90275 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Greensboro Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 01/11/05 Greensboro, Maryland 22 Name and Address of Facility
Fleegle and Helfenbein Funeral Home, PA
PO Box 160 Greensboro, Maryland 21639 21. Signature of Fureral Service Licensee Ku 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** LEUMONIA disease or condition resulting in death) week /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): the attending physician Be Completed by Physician/Medical as the l 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pg 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 Yes 1 Yes 2 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatienf Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 5 Pending 1 Natural Injury 1 Yes 2 No death. 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) < 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryland		tment of F ificate of			giene Reg. Né	711115	01285
	Physici	an	1. Decedent's Name (First, Middle, Las			SE	=101	2. Date of De			3. Time of Death
A Second	/Medic Examir		4a. Facility Name (If not institution, give		F	4b. City, Town, o	r Location of Dea	th 1 - 1	4c	County of Dear	5 15:05M
*	Funeral		5. Social Security Number 6. Se		TR/	If Under 1 Year	M D P If Under 24 Hr		<u> </u>	ALTIM 9. Bird	thplace (State or Foreign
£ c.	Director		2/8-48-8/33 Usual Residence of Decedent	□M 2XF 56	Yrs.	Months Days	Hours Mir	03-2	2 - /	948 M	naryla.nd
	faryland show	J.	10a. State 10b. County		Town or Loca						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th the N or 28e-f e notifi	Director	MARYland WICO 10e. Street and Number	MICO DE	IMAR	10f. Zip Code	-		10g. Cit	tizen of What Co	, ,
	ns 235	Funeral D	33269 Melso	12. Was Decedent Ever in U.S.	. 13. W	Z 1 8		Specify Yes or No-		LSA 14. Race - Ame	arica <i>n</i> Indian
9600	72 hours after death with the Maryland naturel', or Items 23s or 28e-f show offsal Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	lf Y	Yes, specify Cuba	Specify:	rto Rican, etc.)		Black, Whit	
21215-0036	n 72	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give Ki	nt's Usual Occup nd of work done O NOT use retired	durina most of wi	prking	16b. K	ind of Business/	Industry
1212			17. Father's Name (First, Middle, Last)	College (1-401 5+)	H	omem		me (First, Middle,		esidei	nce
Maryland	e d la be	To Be	Thomas Edw	ard ALLE	N	į	^	_		0	Reary
Mar	d 2 shoth and 7 is m		19a. Informant's Name/Relationship (7) ANTheny John				SON RO	ural Route Numbe	eln		Zip Code)
ore,	of Hi of Hi if iter		20a. Method of Disposition 1 Burial 2 Cremation 3	20b. Pla Cen	ice of Disposit metery, crema	tion (Name of tory or other place	(9)	Date	20c. Lo	ocation - City or	Town, State
Baltimore,	그 돈 만 근		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License	Sha	22.1		ss of Facility	13-05	De	wer, s	Delo Home INC
Ä	Depa Impo		Thomas R. 23a. Part 1. Enter the disease, or comp	Trader	12	LoTUS	57 : 0	Dover,	2	21 197	801
4	f nysician		shock, or heart failure. List only of Immediate Cause (Final disease or condition	ine cause on each line.					rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseque		STREET	00	BLEE C)		3 days
	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Sue to (or as a conseque		2111		SICEL			5 access
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68760,	ficate be executed physician and is the burial-transit	edical	(d							
.O. Box (death certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	leath 3□E	ctopic pregnancy other (specify)				23d. Date of deli Month	very Day Year
O	requires that the de been signed by the hould be detached	by Ph	Part II. Other significant conditions co	ntributing to death but not result	ing in the und	erlying cause give	en in Part I.	23e. Did to			the cause of death?
cord	> 11 0	leted						1 □ Y 24a. Was a		1	obably 4 Unknown
Vital Records,	icien: The law certificate has b rector, page 2 sl	e Completed	25. Was case referred to medical				26 Place of De	autops perfor	sy med? 2X No	prior to death?	topsy findings available completion of cause of
of Vi	Physicien: this certific ral director,	To B	examiner? 1 □ Yes 2 No 27. Mapner of Death	Hospital: 1 Inpatient 2 EF	R/Outpatient	3 DOA Othe	er: 4 🗆 Nursing I	Home 5 Resid	ence (sify)
Division	ending I sath. or: After he funer	ation	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injury Work M 1 🗆	yes 2 □ No	28d. Describe he	ow injur	у оссигива	
Divi	Hospital or Attending 24 hours after death. Funerel Director: After tely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stree	t, factory, office		28f. Location (S City or Town	treet an n, State	d Number or Ru)	ral Route Number,
	To the Hospital or Attending Physicien: within 24 hours after deals To the Funerel Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one) (Check only one)	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death o	ccurred at the timestigation, in my or	ne, date and place pinion, death occ	e, and due to the curred at the time, d	ause(s) late and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier		1E01(19			2	29d. Dat	e signed (Month	n. Day, Year)
		1	30. Name and address of person who co	Della Cause of death (Item 2	OCTO	RI RES	5-00	O J)	ANL	PARY	9 2005
			SUSAN BELL, THE	JOHNS HOPK	INS HO	SPIMAL	, BALTI	MORE,	MA	RYLAN	10,21287
	Sta Registr	te ar	31. Date filed (Month, Day, Year) JAN 1 2 2005	32. Registrar's Signatur	TO CO						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23b & State of Maryland / Department of Health and Mental Hygien 20 05 1- State Registrar 26 per Dr 1/5/05 WCHD/SH Certificate of Death Item 27perDrog No.1/5/05 WCHD/SH 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** William <u>Edward Swope</u> January 4 2005 5:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 756 Largo Drive Washington Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F 219-20-3762 Yrs. Director 77 08/11/1927 PAUsual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-1 shows the Medical Examiner must be notified at Director 1 XYes 2 ☐ No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 756 Largo Drive 21740 US Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Clerk Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Matilda Geraldine Woolridge John Wesley Swope, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dorothy J. Swope, Wife 756 Largo Drive, Hagerstown, MD 21740 item 27 l 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Broadfording Ch. Cem 01/08/2005 | Hagerstown, MD 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Europeal Service Licensee 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** CARDIO PULMON ARY NIA /Medical Due to (or as a consequence of): Examiner Metastatic Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CANCER 3 Probably 4 □Unknown LUNG 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate 1 ☐ Yes 2 3 10 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No 2 ☐ ER/Outpatient 3 ☐ SOA Other: 4 Nursing Home 5 Residence 6 Temer (Specify) Certification: To 1 Inpatient within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and DINECTOR RAD 29c. License number 29d. Date signed (Month, Day, Year) MD. CENTED 39518 MID. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-741

DHMH 17 Rev 1/2001

State Registrar D. R. Cornell, M.D.,

31. Date filed (Month, Pay, Year) 2005

32. Segistrar's Signature

11110 Medical Campus Dr., #129, Hagerstown, MD 21742

			For State	State of Maryland /	/ Depa		th and Men	tal Hygie	ne 2005	0128.
	Physici /Medic			JDERS		imouto or boa	2. 0	Reg. Pate of Death Month	Day Year 3 2005	3. Time of Death
	Examir		4a. Facility Name (If not institution, give s WASHINGTON COUNTY I			4b. City, Town, or Local HAGERS		0	4c. County of Dea WASHI	
	Funeral Director		5. Social Security Number 6. Sex 220–28–7961	7. Age (In yrs. last 72	birthday) Yrs.	If Under 1 Year If Ur Months Days Hou	urs Min. 8. D	ate of Birth Month, Day, Ye ${ m T.}~20$,		thplace (State or Foreigr JUNTTY) IARYLAND
	Maryland a-f show	ctor	10a. State 10b. County MARYLAND WASHING:	10c. City, To	own or Loc	ation HAGERS	STOWN			10d. Inside City Limits 1⊠Yes 2□No
	with the	I Dire	10e. Street and Number 12814 POINT SALEM	POAD		10f. Zip Code 217		10g.	Citizen of What Co	-
336	wilt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. Ortant: if Item 27 is marked other than "naturel', or Items 23a or 28a-f show injury or other treumetic event, the Madical Examined must be nutified at any or other treumetic event, the Madical Examined must be nutified at a.g	by Funeral Director		12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		/as Decedent of Hispania Yes, specify Cuban, Mer		Yes or No- n, etc.)	14. Race - Ame Black, Whit	erican Indian,
21215-0036	thin 72 hou e. an "nature Medical E	Completed	15. Decedent's Educ (Specify only highest grade	cation 16 completed) College (1-4or 5+)	6a. Decede (Give k life. D	ent's Usual Occupation ind of work done during O NOT use retired)	most of working	16b). Kind of Business	
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Maryland	d Mental parkad o	ToB	RALPH ISAIAH MOSER	Original and the second	A. 14		SEPHINE			
-	1 and 2 sho Health and Iom 27 is ma		19a. Informant's Name/Relationship (Ty) DARYLL A. SOUDERS/			Address (Street and Nu CRKSHIRE LAN				Zip Code) 7050
Baltimore	pernit. Pages 1 Department of He Important: if Iten any njury or oth		20a. Method of Disposition 1 02 Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Access	emoval from State BOON	SBORC	ition (Name of atory or other place) CEMETERY Name and Address of F AST FUNERAL	01/08/2 facility 760	005 BC	. Location - City or OONSBORO, Jational	MARYLAND
	Physician /Medical Examiner physician and physi	cal Examiner	23a. Par 1. Enter the disease, or a mpli shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):		BOO h as cardiac or resp	piratory arrest,	Marylan	Approximate Interval Batween Onset and Death Chikubur
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	To the Hospitel within 24 hours a To the Funerel C completely filled i	Medical	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examination	ician: To the best of my knowled ler: On the basis of examination a and manner stated.	dge, death and/or inve	occurred at the time, date estigation, in my opinion,	e and place, and di death occurred at	ue to the cause the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
)	To t withi To tl	M	29b. Signature and title of certifier	W, MD		29c. License numb			Date signed (Month	
51	1-6	ľ	30. Name and address of person who co	mpleted cause of death (Item 23a Tigforn STNUL	a) (Ty/pe, P		2. B	Kesti	ren M	005-
	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 5 20	32. Fegistrar's Signature	1	cute)		*		

Sales Representative Industrial Battery 15. Montgomery Rea Shafer 19a. Informant's Name/Fleationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number. City or Town, State, Zip Code) 276.44 Parkway Rd., Easton, MD 21601 20a. Method of Deposition 19b. Mailing Address (Streat and Number or Rural Route Number. City or Town, State, Zip Code) 276.44 Parkway Rd., Easton, MD 21601 20a. Method of Deposition 19b. Mailing Address (Streat and Number or Rural Route Number. City or Town, State, Zip Code) 276.44 Parkway Rd., Easton, MD 21601 20a. Method of Deposition 19b. Mailing Address (Streat and Number or Rural Route Number. City or Town, State, Zip Code) 276.44 Parkway Rd., Easton, MD 21601 20a. Method of Deposition 19b. Mailing Address (Streat and Number or Rural Route Number. City or Town, State, Zip Code) 20a. Method of Deposition 19b. Mailing Address (Streat and Number or Rural Route Number. City or Town, State, Zip Code) 20a. Method of Deposition 19b. Mailing Address (Streat and Number or Rural Route Number. City or Town, State, Zip Code) 20a. Method of Deposition 19b. Mailing Address (Streat and Number or Rural Route Number. City or Town, State, Zip Code) 20a. Method of Deposition 10b. Basiling Address (Streat and Number or Rural Route Number. City or Town, State, Zip Code) 20a. Method of Deposition 10b. Basiling Address (Streat and Number or Rural Route Number. City or Town, State, Zip Code) 20a. Method of Deposition 10b. Basiling Address (Streat and Number or Rural Route Number. City or Town, State, Zip Code) 20a. Method of Deposition 10b. Basiling Address (Streat and Number or Rural Route Number. City or Town, State, Zip Code) 21b. Basiling Address (Streat and Number or Rural Route Number. City or Town, State, Zip Code) 22a. Method of Deposition of Code State				1 - For State Registrar	State of Mary	land / Depa			fental Hy		-	01288	
Caspar Bernhard Shafer City Town of Location of Basis Security Free Property Security Fre		Physici	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tim							3. Time of Death		
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. David H. Smith, 29466 Pintail Drive, Easton, MD 21601 State 31. Date filed (Month, Day, Year) 32. Relistrar's Signature				(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. David H. Smith, 29466 Pintail Drive, Easton, MD 21601 State 31. Date filed (Month, Day, Year) 32. Relistrar's Signature		To the To the comp	×								Day, Year)		
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	Physicia	an	Decedent's Name (First, Middle, Last)	2. D	Reg. No ate of Death fonth Da	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
	Examin	er •	Northwest Hospital	Randellstown		Baltimore
	Funeral Director		5. Social Security Number 6. Sex 1 \square M 2 \square F 86 Yrs.	If Under 1 Year If Under 24 Hrs. 8. D Months Days Hours Min. 9 /	ate of Birth Month, Day, Year) 29/1918	9. Birthplace (State or Foreign Country) Kentucky
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Le	ocation		10d. Inside City Limits
	Manyl f sho	ō				1√∑Yes 2 No
	r 28a	Director	Md. Baltimore Pikesv 10e. Street and Number	10f. Zip Code	10g. Cit	tizen of What Country?
	h with	ai D	7 Slade Ave., Apt.1A	21208	US	SA
	ems a	Iner		Was Decedent of Hispanic Origin? (Specify \ If Yes, specify Cuban, Mexican, Puerto Ricar	res or No-	14. Race - American Indian, Black, White, etc.
36	or It	by Funerai	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 ☐ No Specify:	, 610.)	
Ö	72 hours after death with the Maryland natural; or Items 23s or 28s-f show Jeal Exard or must be codified at	q pa	Year or Dates:	dent's Usual Occupation	405-16	Specify: White
21215-0036	in 72 n "na	Completed	(Specify only highest grade completed) (Give	b kind of work done during most of working DO NOT use retired)	16b. K	find of Business/Industry
212	d with	mo	Elementary/Secondary (0-12) College (1-4or 5+)	omemaker		
밀	al Hylla d other	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (Firs	t, Middle, Maiden	Sumame)
yla	Ment Ment arked	P	Robert Bryant		Livesa	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event; the Macilial Examinat must be modified at once.	d		ng Address (Street and Number or Rural Rou		
o,	1 and Healt em 2 ither		Ira R. Taylor (Son) 7 S1 20a. Method of Disposition 20b. Place of Dispo	ade Ave, Apt 1 Pik		e, Md • 21208 ocation - City or Town, State
nor	ages int of t: If It		1 StBurial 2 □ Cremation 3 □ Removal from State 3 delin	matory`or other place)		
Baltimore,	artme ortan injur		4 Donation 5 Other (Specify)	1/8/05	Need	dmore,Pa.
ä	permi Depa Impo any is		David J. Starbler, fr. # M01035 H	^{2.} Name and Address of Facility Lincoln Hwy <u>Ome,Inc. Linciln</u> H	arrison	nville.Pa.17228
	*		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician		Immediate Cause (Final	la		Onset and Death
	/Medical Examiner		disease or condition resulting in death) a. Due to/(or as a consequence of):			
×	LXammici	<u></u>	Sequentially list conditions, b. IS Ch2m, C	Bowl		
	ted nsit	nine	rease. Enter Underlying Cause (Disease or injury			
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8760,	ificate be executed physician and as the burial-transit	icai	d			
9	rtifica ng ph	Medi	IF FEMALE:			
Вох	death certific e attending pl d for use as t	Physician/Med	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	JEctopic pregnancy	-	23d. Date of delivery
0.		/sici	1 Yes 2 No 9 Unknown 5	Other (specify)		Month Day Year
<u>α</u>	that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the u	Inderlying cause given in Part I.	23e. Did tobacco i	use contribute to the cause of death?
Records,	es pe	d by		,,,,,	1 ☐ Yes 2	_
Ö	w requir s been si should	Completed		2	24a. Was an	24b. Were autopsy findings available
Re	The lav	omo			autopsy performed?	prior to completion of cause of death?
Vital		BeC	25. Was case referred to medical	26. Place of Death Che	Yes 2 No	1 Yes 2 No
of <	Attending Physiclan: r death. ector: After this certific by the funeral director.	To	examiner? 1 Yes 2XNo Hospital: 1 Vinpatient 2 ER/Outpatient	nt 3 DOA Other: 4 Nursing Home	5 Residence	6 ☐ Other (Specify)
בַ	ing Ph	on:	27. Manner of Ceath 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year) 1 Injury	of 28c. Injury at 28d. I Work?	Describe how inju	ry occurred
sio	Attending er death. rector: After by the funer	icati	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No		-thirt
Division	or A efter Direction by	Certification:	determined 4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		cation (Street an City or Town, State	nd Number or Rural Route Number, e)
_	Hospital	N C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	th occurred at the time, date and place, and d	ue to the cause(s) and manner as stated.
	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funer	edical	(Check only 2 Medical Examiner: On the basis of examination and/or in one)	ivestigation, in my opinion, death occurred at	the time, date and	d place, and due to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier	29c. License number	29d. Da	te signed (Month, Day, Year)
			Alice 1-11110	1-143974	Jan	nary (-, 2000
,	,, _		30. Name and address of person who mp eted cause of death (Item 23a) (Type,	Print) Alike L-15:41	7 /	1
	4-5	to	31. Date filed (Month) Ray Yearly 32. Registrar's Signature	Bandallotour.	hary 10	7
	Sta Registr		JAN 07 2005	neith s	*	
				A - Andrew		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician 9, 2005 Taylor January 1:37 Carolyn Marie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** St. Mary's Hospital St. Leonardtown Mary's Under 1 Year | If Under 24 Hrs. onths | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 F 13,1961 Director 43 Delaware 221-52-6198 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, the Medical Examiner reserved. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10h Counts 1 ☐ Yes 2 M No Director Lexington Park St. Mary's Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20653 22097 Spring Valley Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♠ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Rental Agent Housing 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Liv Bjarnhild Norum Julian Glover ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1106 Powerhorn Drive, Newark, Delaware 19713 John Erick Glover / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Saints Cemetery 1-18-2005 Wilmington, DE 22. Name and Address of Facility 21. Signature eral Service Licens Brinsfield Funeral Home, P.A. M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death stage Immediate Cause (Final **Physician** isease disease or condition resulting in death) /Medical Due to (or as a consequence of). **Examiner** repatio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Ahenne the attending physician and Due to (or as a consequence of): Physician/Medical d the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 □Unknown 1 Yes Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1.XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA Sit filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Manner of Death 28b. Time of After or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To the To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 11.05 D 47066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., Avani D. Shah, 22650 Cedar Lane Court, Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 2 2005 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

			1 - For State Registrar	State of	Maryland		artment rtificate			and Me		giene Reg. No.	711115	01291
	Physici /Medic Examir	cal	Decedent's Name (First, Middle, in GRACE 4a. Facility Name (If not institution, grants)		THOMAS		4b. City, 1	Town, or	Location o		2. Date of De Month JAnne	Day 4c.	County of Death	
	Funeral Director		3512 Hubbar. 5. Social Security Number 6 578-06-1966		Age (In yrs. last		If Under Months		If Under:	Min.	8. Date of Bir (Month, Da	th y, Year	947 9. Birthy Cou	place (State or Foreign ntry)
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. If a Medical Evantment must be notified an once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Prince 10e. Street and Number 3512 Hubbard Roa 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest of the state	George's d # 104 12. Was Deced Armed Ford 1 Yes, Give Year or Dail Education grade completed) College (1-4) St)	10c. City, ĭ Lat Lat lent Ever in U.S. es? Right Aor 5+)	13. 16a. Dece (Give iffe.	veation r Hil 10f. Zip 20 Was Deceddif Yes, specifyes, specific yes, specific work of work of work of work of work of the sewife	1s Code 785 ent of His fy Cuban In No Coccupat R done do e retired)	spanic Origin, Mexican Specify: tion uring most	gin? (Spec t, Puerlo F t of workin or's Name	January cify Yes or No lican, etc.) g (First, Middle, nderson	y 24 10g. Citi: U	zen of What Cou. S.A. 14. Race - Ameri. Black, White, Specify: B1 nd of Business/In Private Sumame)	nadad 10d. Inside City Limits
	os 1 and 2 sh of Health and of item 27 is m or other traum		19a. Informant's Name/Relationship Lemar Thomas/H 20a. Method of Disposition 1 □ Burliai 2 ☆ Crematiop 3	usband	20b. Plac	3512 e of Dispo	_	rd Ro	oad I		ver Hi	11s,	r Town, State, Zip Marylan cation - City or To	d 20785
Baltimore,	permit. Pages Department of the Important: If ite any injury or of once.		4 □ Donation 5 □ Other (Spe 21. Signature of Fun al Service	cify)	/	22		Address	of Facility		. Jenk	ins	rdale,Ma Funeral aryland	Home
8760,	Physician //Medical Examiner and potaginal the prital-transit	Ilcal Examiner	23a. Part1. Enter the disease, or co shock, or heart ailure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Arte Due to (o	h hae.	eve to							Dis ease	Approximate Interval Between Onset and Death
O. Box 6	The law requires that the death certificate be executed the tas been signed by the attending physician and oage 2 should be detached for use as the burtal-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live bin	ome of pregnancy h 2 Fetal de nt at time of death n	ath 3	Ectopic pre Other (spe					2	3d. Date of delive Month	ery Day Year
cords, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to dea	th but not resultin	ng in the u	nderlying ca	use giver	n in Part I.		101	∕es 2□	No 3 ☐ Prob	
Division of Vital Records,	ding Physician: h. After this certifics funeral director,	Certification; To Be Completed	25. Was case referred to medical examine? 1	28a. Date of (Month) be 28e. Place of	patient 2 □ ER. Injury Day Year) 28 Injury - At home Injury - At home Injury - At home	b. Time of Injury	28 M	c. Injury : Work?	4 🗆 Nur	rsing Homo 28	1 ☐ Yes Check onf o e 5 ☐ Resid	med? 22 No one dence 6 now injury	prior to condeath? 1 □ Yes	
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical Ce	29a. Certifier 1 Certifying I (Check only one)	Physician: To the baseminer: On the basemanner	is of examination	dge, death and/or inv	occurred a restigation, i	t the time	e, date and nion, deat	d place, an	nd due to the o	cause(s) a	and manner as st place, and due to	ated. the cause(s)
2	To t viith:	W	29b. Signature and title of certifier 30. Name and address of person where the second	o pleted cause	of deat (Item 23	Ba) (Type,		License		27 Ch:			e signed (Month, were 4)	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 6 200	2. Reg	gistrar's Signature	Spen	K)		·			1,-	7	, ~ 0

Oleavon Eugene TAYLOR Baltimore, Maryland 21215-0036

			for Stata		State of M	aryland		artment of F <i>tificate of</i>		Mental Hy	- (2000	01000
			Registrar 1. Decedent's Name	(First, Middle, Las	t)		- 061	incate or	Dealit	2. Date of De		2000	3. Time of Death
	Physici /Medic		CLEAV	ON	Ε.	TAY	LOR			Janua	VY Day	1, 2005	- 10:20 PM
	Examin		4a. Facility Name (If	not institution, give	street and number)			4b. City, Town, o	or Location of Dea	ath	4c.	County of Deat	h
					TY HOSPITA				HAM		PR	INCE GE	ORGE 'S
	Funeral Director		5. Social Security Nu 416-34-68	29	7006	e (In yrs. Ias 76	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		rth ay, Year) per 1	1928 9. Birti 5 Ala	nplace (State or Foreign untry) bama
	and w		Usual Residence of I	10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Marylan -f show lied at	tor	MD I	PRINCE GE	ORGE'S	COI	LLEGE	PARK					1 √2 Yes 2 □ No
	h the	Irec	10e. Street and Num					10f. Zip Code			10g. Citi	izen of What Co	untry?
	239 c	alD	5002 Lake	eland Roa	.d			207	740		Ţ	J.S.A.	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumetic event, if a Medical Examination resulted at once.	by Funeral Director	11. Marital Status 1 □ Never Marrie 3 □ Widowed		12. Was Decedent Armed Forces? 1 ☐ Yes 2 (X) If Yes, Give Year or Dates:			Vas Decedent of I f Yes, specify Cub I□ Yes 2⊠ No		Specify Yes or No orto Rican, etc.)	0-	14. Race - Ame Black, White Specify: B1	
2-0	72 ho	sted	(Special	15. Decedent's Ed fy only highest grad	ucation		16a. Deced	lent's Usual Occup	pation	ndkina	16b. Ki	nd of Business/	Industry
21215-0036	d within 3 giene. er then "r	Completed	Elementary/Secon		College (1-4or !	5+)	life. L	tence	d)	DIKING	G	overnme	nt
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yla	should be ind Mental s marked o umetic eve	2	Richard	Taylo					Pearl	Thomas			
, Maryland	1 and 2 sho Health and I em 27 is ma		19a. Informant's Nac Helen Ta	me/Relationship (7 ylor/Wife			5002	Lakeland	Road Co	Rural Route Numb	rk,	Marylan	d 20740
Baltimore,	Pages 1 nent of Ha nt: If iter iry or oth		20a. Method of Dispertition 1 ☐ Burial 2 🗵		Removal from State			sition (Name of natory or other pla		Date		cation - City or	
ij	permit. Pages Department of Importent: If it any Injury or c		`4 ☐ Donation 21. Signature of Fug	5 Other (Specify		Riv		e Cremat					Maryland
Ba	permit. Departr Importe any Inje			26	- 1		7	474 Land	over Roa	. B. Jen d Landov	er,		
	Physician /Medical Examiner		Immediate Cause (f disease or condition resulting in death)	Final 1	a. Due to (or as	cand, a conseque	ence of):	In Car	ng, such as cardi	ac or respiratory a	irrest,		Approximate Interval Between Onsel and Death Ominute
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	edical Examiner	Sequentially list conf any, leading to im- cause. Enter Under Cause (Disease or in that initiated events resulting in death) L		C. Due to (or as								
P.O. Box 6	that the death certifi led by the attending detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal d	leath 3□	Ectopic pregnanc Other (specify)	у		2	23d. Date of deli Month	very Day Year
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Vital	Physician: The this certificate ral director, pag	Be	25. Was case referre examiner?		Hospital:		/	Ott	000	eath (Check only			
o	문 문 문 문	. To	1 Yes 2 4		28a. Date of Inju		R/Outpatien 8b. Time of	t 3 DOA	4 🗆 Nursing	Home 5 ☐ Resi			ify)
ion	Attending Ph r death. ector: After th by the funeral	atlor	1 ☑ Natural 2 ☐ Accident	5 Pending investigation		y Year)	Injury	Wo	rk? Yes 2 □ No				
Division of	of or Atterdes	Certification:	3 Suicide 4 Homicide	6 Could not be determined	286. Place of in	ury - At hom c. (Specify)	ne, farm, str	eet, factory, office		28f. Location (City or To	Street and wn, State)	d Number or Ru.)	ral Route Number,
	To the Hospitel or Attendwithin 24 hours after death To the Funerel Director:	Medical C	29a. Certifier (Check only one)	12 Certifying Phy 2 Medical Exam	ysicien: To the best iner: On the basis o and manner st	f examinatio	ledge, death on and/or inv	occurred at the tile restigation, in my o	me, date and place opinion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and	/ //	///	110		29c. Licens			_	e signed (Month	
	(10)		30. Name and addre	ess of person who	completed cause of o	leath (Item 2	23a) (Tyna	m D G	5139	8	Jan	uary	1, 2005 D 20707
K	10		James 31. Date filed (Month	A. Sher	O MD	575	Mair	Street	- Suite	351	Lau	vel, M	D 20707
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jan. 2, 2005 **Physician** Year Phuong Truong 8:00a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Silver Spring 410 Dennis Avenue Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 1 1/18/1906 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 98 Hours 1 M 2 XF 216-92-2954 Yrs. China Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2√ No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 Dennis Avenue 20901 or Items 23a USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Asian 3 ➡Widowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental Ping Chang See Leung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toan Chau/Son item 27 410 Dennis Avenue Silver Spring, Md 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State tant: If it Injugar 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington 1/05/05 Adelphi, Md. 1 4 ☐ Donation 5 ☐ Other (Spec Departr Importu any Inji f Funeral Service Philip do Rinaldi Funeral Service, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician ARTERIES COROWARY yeurs resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 KResidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1★ Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 0029616 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , M.D 636 UNIVERSITY BLVD, EAST_SILVER SPRING -MDZO 901 TRUONG X. HOANG

State

Registrar

31. Date filed (Month, Day, Year)

JAN 05 2005

		1 - State Registrar Amended #26			artment of H	Death	2. Date of Death Month	Day Year	3. Time of Death
Physici /Medi			ook		,		January	3, 2005	10:00 A
Examir	ner	4a. Facility Name (If not institution, gi	ive street and number)			r Location of Death		4c. County of Deat	
uneral				In yrs. last birthday)	If Under 1 Year	derick If Under 24 Hrs.	8. Date of Birth	Freder:	ick hplace (State or Fore buntry)
irector		316-12-1482 Usual Residence of Decedent	1 □ M 2 🗓 F	91 Yrs.	Months Days	Hours Min.	(Month, Day, Y Aug. 10,	1913 Ind	iana
Mo		10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Lim
3e-f sh liffed	ctor	Maryland Frede	rick		F1	rederick			¥∏Yes 2 ☐ 1
B or 21	Funeral Director	10e. Street and Number	Designs		10f. Zip Code	21701	10g	. Citizen of What Co United	
ms 23	nera	1614 Wheyfield 11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.		ispanic Origin? (Spe in, Mexican, Puerto I	cify Yes or No-	14. Race - Ame	ncan Indian,
Important: If them 27 is marked other then "natural", or Items 23a or 28e-f show any njury or other traumatic event, I'm Medical Exam and must be invitibled at once.		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 X No	in, Mexican, Puerto I Specify:	Rican, etc.)	Black, White	e, etc. hite
igal E	Completed by	15. Decedent's E	Education	16a. Dece	dent's Usual Occup	ation	16	b. Kind of Business/	Industry
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other then 'vent, the Me		12 17. Father's Name (First, Middle, Las	:t)	Hc	memaker	18. Mother's Name	(First Middle Ma	Own Home	e
Kedo	To Be	Raymond Edwards					a Boswel		
s mar	-	19a. Informant's Name/Relationship	(Type, Print)					ity or Town, State, Z	
m 27 her tr		Peg Mauzy / Daug						, MD 2170	
ant: If ite ury or ot		20a. Method of Disposition 1 Daurial 2 Cremation 3	Removal from State		matory or other place	e)		c. Location - City or	
Important: If it any njury or one		' 4 ☐Donation 5 ☐ Other (Spec 21. Signature of Juneral Service Lice		Converse		Jan. ss of FacilityStau		onverse,	Indiana
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1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Jan 2,2005 Traver 6:07 /Medical LaVern 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Beverly Health Care Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🛱 F 43 281-58-6238 Director Feb. 26, 1961 OH Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "naturel", or itams 23e or 28e-f show the Medical Examinar must be notified at 1XXYes 2 No MD Washington Hagerstown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 750 Dual Highway death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. a filad within 72 hours after all Hygiene.
other than "naturel", or Ital 1 Never Married 2 Married Specify: White 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Paralyzed Never Worked 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any linity or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Daniel Traver Faye Ε. Skiles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Faye Mallory/ Mother 128 Jennings Dr., B-2, Martinsburg, Wv. 25401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Hagerstown Crematory Jan.3,2005 Hagerstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burner Trade Services P.A. 1037 Dual Place, Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or resshock, or heart failure. List only one cause on each line. **Metastatic breast carcinoma** Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): signed by the attending physician and d be detached tor use as the burial-transit The law requires that the death certiticate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 3 Ectopic pregnancy
5 Other (specify) ENTIFICATION APPROVED BANIEURAL EXAMINER IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Quadreplegia with complications 3 ☐ Probably 4 Unknown should l 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Aftar this certificate has tuneral director, page 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

Yes 25 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Netural Accident 5 Pending investigation 1982 1 ☐ Yes 2 X No unk. Motor vehicle accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide street To the Hospital within 24 hours a To the Funerel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28365 ew 30. Name and address of person who completed cause of cleath (Item 23a) (Type, Print) Strat Hagestonm MD 21790. ne 31. Date filed (Month, PAY) Yet) 5 32. Registrar's Signature State Registrar

amend item#23a-5,27,28a-f, perfit to Black Indelible Ink Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. Ne.

Division of Vital Records. certificate has Hospitel or Attending Physician: funeral c After s after death. filled in by To the Hospitel within 24 hours a To the Funeral I

25. Was case referred to medical Be examiner' 1 X Yes 2 □ No 27. Manner of Death 28a. Date of Injury (Morth, Day Certification: 1 Natural 5 Pending 2 Accident 3 Suicide investigation 9/05 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 4 | Homicide street 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? Injury 1 ☐ Yes 2 No 2:15 AM

Other: $_{4}$ Nursing Home $_{5}$ Residence $_{6}$ Nother (Specify) At Scene 28d. Describe how injury occurred arriver of vehicle involved in motor venucle accident

28f. Location (Street and Number or Rural Route Number City or Town, State) 11942 Kibkin Rd Greenshore, MO

Tamet

29c. License number OCME D62066

29d. Date signed (Month, Day, Year) January 9, 2005

Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pamela E. Southall, Mil

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) State

32. Registrar's Signature



Registrar

				State of M	aryland		ment of F ficate of		Mental Hy	giene _{Reg. No.} 2 (105	0129
	Physiciar		-	ams					2. Dete of De Januar	Day	005	3. Time of Death 5:45 AM
	/Medica Examine	4e Fecility Neme (If not	institution, give s	treet and number)			4	4b. City, Town, o	Location of Deat	4c. County	of Death	
		Julia Manor 5. Social Security Number				A E : 45 - 4 - 1	f Under 1 Year	Hagersto			ingto	
	Funeral Director	220-03-2152 Usual Residence of Deci	112	M 2□F	ge (In yrs. las 86		onths Days	Hours Mir		y, Year)	9. Birthp Coun	lace (State or Foreign try) MD
	ylend		. County		10c. City,	Town or Locat	ion				11	0d. Inside City Limits
	Be-f at	MD V	Vashingto	on	На	gersto	wn					1⊠ Yes 2□ No
	with th	10e. Street and Number	`\				10f. Zip Code 21740			10g. Citizen of \	What Coun	try?
20	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Heelth and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at once. To Re Completed by Europe Director	46 Bethel S 11. Maritel Status 1 Never Married 3 Widowed 4	1. 2 Married	2. Wes Decedent Armed Forces? 1 X Yes 2 ☐ If Yes, Give		1		lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	US 14. Rad Blad	e Americk, White, 6	etc.
Baltimore, Maryland 21215-0020	led within 72 hours e lygiene. Ver than "naturel; o nt, the Medical Example Compiled to the formal and the for	15. I (Specify or	Decedent's Education of the second se			16a. Decedent (Give kind life. DO	t's Usual Occup d of work done o NOT use retired	ation during most of wo	orking	16b. Kind of B		
7	filed with Hygiene wither that ant, the	12			,	C ₁	ustodia				ankin	g
and	d be file and other	17. Fethers Neme (First,		iams					me <i>(First, Middl</i> e, e Olivia		10)	
aryl	should Ind Meni	19a. Informant's Name/F				19b. Mailing A	ddress (Street		iural Route Numb		State, Zip	Code)
X,	and 2 selith e n 27 is	Edward L. S	Strawthe	r, Nephe				Lane, G	ermantow	m, MD 2	0874	
more	Peges 1 nent of Hi int: If iten iry or oth	20a. Method of Disposition 1 □ Burial 2 □ Cre 4 □ Donation 5 □	emation 3 □Re	moval from State	cern		on (Name of ory or other plac Cemeter	•	Date 1/10/05	20c. Location -	-	
Balt	permit. Depertm Importal any Inju	21. Signature of Eureral	Service Licensee	LR.			ame and Address	ss of Facility	Contract of the second	Minnic	h Fun	eral Home
		23a. Part1. Enter the dis shock, or heart failu	sease, or complicate. List only one	ations that caused cause on each li	d the deeth. ne.	Do not enter th	ne mode of dyin	g, such as cardia	c or respiratory a	rest,		Approximate Interval Between
A.	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a.	Hyper	tere	ive	Cardy	ovoscu	ley d	Sease	 	Onset and Death
	outed and rensit	Sequentially list condition	b.	Ao	rfic	s a consequent	resis				,	154
68760,	tificate be executed g physician end es the buriel-trensit	Sequentially list condition if any, leading to immedicause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last	ate c.			s a consequen						,
	≔ ⊘ 0		d.									
B	nat the death cert d by the ettendin letached for use Physician/M	Part II. Other elgnificant	conditions contr	ibuting to death b	ut not resultir	ng in the under	rlying cause give	en in Part I.	23b. Did	obacco use co	ntribute to	the cause of death?
s, P.C	v requires that the death cert been signed by the ettendin should be detached for use.								10	Yes 2□ No	3 Prob	ably 4 ⊠Unknown
Division of Vital Records, P.O.	 The law requires that the death centered has been signed by the ettendin pege 2 should be detached for use. Completed by Physician/N 									an autopsy rmed?	ava	re autopsy findings ilable prior to npletion of cause eath?
<u> </u>	Cete h								101	es 2 Milo	1 🗆	Yes 2□ No
<u>=</u>	Physician: this certific rel director,	25. Was case referred to examiner?	-	spital:	ent 2□ER	2/Outpotiont	3□ DOA Othe		ath (Check only o			
on of	Attending Physics of death. ector: After this comby the funerel direction: To		Pending investigation	28a. Date of Inju (Month, Da	ry 28	Bb. Time of Injury	28c. Injury Work		Home 5 Resident Resid	iow injury occurr		
Divis	tal or Attending P rs efter death. el Director: After t led in by the funer Certification:	3 Suicide 6 C	Could not be determined	28e. Place of Inj building, etc		e, farm, street,	factory, office		28f. Location (S City or Tox	Street and Numb m, State)	er or Rural	Route Number,
	Hospi 24 hou Funer tely fil	29a. Certifier SEC (Check only 2 In	Certifying Physic Medical Examine	clan: To the best of r: On the basis of and manner sta	examination	dge, death occ n end/or invest	curred at the timi gation, in my of	ne, date and place pinion, death occ	e, and due to the ourred at the time,	cause(s) and ma date and place, a	nner as sta and due to	ted. the cause(s)
	To the within 2 To the comple	29b. Signature end title o	f certifier				29c. License			29d. Date signed	(Month, D	ay, Year)
		20 No.	72 6g					5353		1/6/5		
SF.	1-12+1	30. Name end address of Khalid M. W	Jaseem N	4 D 11			•	rstown.	MD 21740			
	State Registrar	31. Dete filed (Month) Ga	N'0"7 200	32. Registra	ar's Signature		-, 1200					

			For State Registrer	State of M	Maryland / D		irtment of F			, ,	iene	005	01298
		¥:	Decedent's Name (First, Middle,	Last)					2	. Date of Deat	th	000	3. Time of Death
	Physici /Medic		AUBREY	PAUL	MILKE	ERS	SON		J	Month anuary	Day	Year 2005	15:10 P M
	Examin		4a. Facility Name (If not institution,	give street and number	r)		4b. City, Town, o	r Location				county of Death	13110 1
100	76		SOUTHERN MARYL			4-1-1	CLINTO		24 Hrs. 0	5 . (5:4)			EORGES
n	Funeral Director		5. Social Security Number 212-34-3450	6. Sex 7. A 1 ★ M 2 ☐ F	Age (In yrs. last birtl 68 y	rs.	Months Days	Hours	Min.	Date of Birth (Month, Day, uly 18	Year)	36 Mary	place (State or Foreign ntry)
	_		Usual Residence of Decedent							dly 10	, 10	Jo mary	Tand
	nylan how	_	10a. State 10b. County Maryland Prince	e George	10c. City, Town Forest								10d. Inside City Limits
	Be-1 e	Director		e deolge	rores	LVI	TT6						12€Yes 2 No
	with th	Dire	10e. Street and Number				10f. Zip Code	207/	7	1	_	en of What Cou	-
	s 23	era	8107 Darcy Roa	12. Was Deceden	t Ever in II C	12.14	Van Danadant of L	2074		fu Van an Na		nited St	
Maryland 21215-0036	J within 72 hours after death with the Maryland Jione r then "netural", or Items 23a or 28e-1 ehow It e Madical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	Armed Forces	s?] No		Vas Decedent of H Yes, specify Cub ☐ Yes 2 No	an, Mexical Specify:		can, etc.)		4. Race - Americ Black, White, Specify: B1	
2-0	72 ho	Completed	15. Decedent's (Specify only highest		16a.	Deced (Give	ent's Usual Occup	ation	t of working		16b. Kind	d of Business/In	dustry
21	ithin ne.	nple	Elementary/Secondary (0-12)	College (1-4o		life. D	O NOT use retire	d)	it of Morking			0	
121	7		17. Father's Name (First, Middle, L	act)			Mechanic	10 Moth	aria Niama //	First, Middle, M	Maida a C	Governm	ent
and	o d la	Be c	Samuel Wilkers	•						Queen	vialuen 3	urname)	
2	s 1 and 2 should be f Health and Menta item 27 is marked other treumetic ev	은	19a. Informant's Name/Relationshi	p (Type, Print)	19b.	Mailin	g Address (Street	and Numb	er or Rural F	Route Number	City or	Town, State, Zin	Code)
	ith a		Arlena W. Mason,	/Daughter	530	06	Stoney M	eadow	s Driv	ve:Fore	stvi	11e,MD.	20747
J.C	ges 1 ar t of Hea ff item or other		20a. Method of Disposition		20b. Place of	Dispos	sition (Name of natory or other place	100	Dat			ation - City or To	
<u><u>E</u></u>	Pages nent of ent: ff it ury or o		1 🔀 Burial 2 □ Cremation : 1 4 □ Donation 5 □ Other (Special Control Contro		Lincol	n C	emetery	J				land, M	iD.
Baltimore,	permit. Pag Department Importent: any injury o		21, Signature of Funeral Service L	Mille	Ø		Name and Addre		For	e Fune 88 Marl restvil	le,	Homes Pike MD. 20	747
			23a. Part1. Enter the disease or of shock, or heart failure. List o	omplications that cause nly one cause on each	ed the death. Do no line.	ot ente	er the mode of dying	ng, such as	cardiac or r	espiratory arre	est,		Approximate Interval Between
	Pnysician	i V	Immediate Cause (Final disease or condition	a Myo	CARDIA	1L	INFA	RKT	ION				Onset and Death
	/Medical Examiner		resulting in death)	- 43	is a consequence o		2-5-0-1	7					
		je je	Sequentially list conditions, if any, leading to immediate	0.	NARY	_	RTFRY	V	ISEA	インド			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		,	,							
oʻ	an an rial-tr	Еха	resulting in death) Last	Due to (or a	s a consequence o	f):							
8760,	icate be executed physician and s the burial-transit	dlcal	1	d									
9	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Med	IF FEMALE:										
Вох	eath certific attending p	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?		e of pregnancy 2 ☐ Fetal death at time of death		Ectopic pregnancy	/			23	d. Date of delive Month	ery Day Year
P.O.	at the de by the a	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 Unknown	at time of death	2	Other (specify) _		-				
	that ed b	by Ph	Part II. Other significant condition	s contributing to death	but not resulting in	the un	derlying cause giv	en in Part I		23e. Did tob	acco use	e contribute to the	ne cause of death?
Vital Records,	w requires been sign should be		DIABETES	MELLI	TUS					1 □ Ye	s 2 🗆	No 3 ☐ Prob	ably 4 Munknown
000	aw re	ompleted								24a. Was ar		24b. Were auto	psy findings available
Ä		Com								autops perforn 1 Yes 2	ned?	death?	mpletion of cause of 2□ No
/ita	certific rector,	Be (25. Was case referred to medical examiner?					26. Place	of Death (C	Check only on			
	Physicien: this certific ral director,	ြ	1 ☐ Yes 2 💢 No	Hospital:	1			4 140				Other (Specify	v)
nc	ling After fune	lon	27. Manner of Death 1 ▼Natural 5 □ Pending			me of	28c. injur Wor M 1	yat k? Yes 2.⊟	111	d. Describe ho	w injury o	occurred	
Division of	deat ctor: y the	ficat	2 Accident investiga 3 Suicide 6 Could no	ot be	njury - At home, fara	m. stre		195 2	-	. Location (St	reet and i	Number or Rura	I Route Number,
Ω		Certification:	4 ☐ Homicide determin	building,	etc. (Specify)	,				City or Town	, State)		,
	To the Hospitel or within 24 hours after to the Funerel Dii completely filled in	edical C	29a. Certifier (Check only) 2 Medical E	Physician: To the bes xaminer: On the basis	at of my knowledge,	death	occurred at the tir	ne, date an	nd place, and	d due to the ca	iuse(s) ar	nd manner as st	lated.
	To the hwithin 24 To the 5 Complete	Medi	one)	and manner s	stated.		29c. Licens						
1	T Wil	_	29b. Signatule and title of certifier				D Ø		HIL	25		signed (Month,	-
0.1	10		30. Name and address of person w	ho completed cause of	death /Itom (22a) (7	Two a S		y 6	1117		0.7	- 5 120	-0>
4	48)			MBHIR, 1	1. D. 500	the	rnMarylar	nd Hosp	ital. 75	5035 Surr	atts	Road, Ili	inter MD.20735
	Sta Registr	100	JAN 0 6 200	5 Seede	trar's Signature	and	e e						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** January 02, 2005 3:30 A M PEARLIE MAE WADDELL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clinton Nursing and Rehabilitation Clinton P.G. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Mooth, Day, Year) 11/18/1936 9. Birthplace (State or Foreign Country)
Washington, DC 6. Sex 5. Social Security Number **Funeral** 1 □ M 68 Director 577-64-2389 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or Itams 23e or 28e-f show traumatic event, the Medical Examiner must be notified at 1- Yes 2 No Director Hyattsville MD P.G. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20785 7520 Greenleaf Road U.S.A Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: hours after 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation within 72 (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na eny injury or other traumatic event, In a Medic once. College (1-4or 5+) Elementary/Secondary (0-12) 12th Nurse Assistant Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Al Williams Helen Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4311 Andover Place; Suitland, Maryland Janice Shaw - Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 01/10/2005 Suitland, Maryland Cedar Hill Cemetery 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Funeral Service Licensee P.O. Box 416: Suitland, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one sause on each line. Approximate Interval Between Onset and Death Congestive Heart FAIlure Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Hyportension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of. Physician/Medical Examiner The law requires that the death certificate be executed DIAbetes mellitus use as the burial-tran Due to (or as a consequence of): Box 68760, attending physician PERipHeral Vasteller Vilease IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 Ø No į 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown ò signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 ☐ Probably 4 ☑ Unknown Blindness 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 🗌 Yes 2X No Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending 1 Natural 2 Accident 1 Yes 2 No death. investigation the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide ö pelli To the Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mo January 05, 2005 anac 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khosrow Davachi, M.D. 7801 Old Branch Avenue Ste#409; Clinton, Maryland 31. Date filed (Month, Day, Year) State 0 6 2005 Registrar

_ (009		For State Registrar	State of	Maryland / De	partment of ertificate o			giene 2005	01300
			1. Decedent's Name (First, Middle	Last)				2. Date of Dea	ath	3. Time of Death
	Physici /Medio		Edward \	Villiam	Wilk			Janua:	rv 1, 2005	7:35 A M
	Examir		4a. Facility Name (If not institution,		ber)	4b. City, Town	, or Location of	Death	4c. County of Deat	h
		ш	5012 Ravenswood			Riverda			Princ	e George's
	Funeral Director		5. Social Security Number 196-20-2862	6. Sex 1 2 M 2 ☐ F	'. Age (In yrs. last birthd 77 Yrs	Months Day		Min. Apr. 12	y, Year) 9. Birtle Co Per	nplace (State or Foreign untry) nnsylvania
			Usual Residence of Decedent					7,51. 72	-, 172/ 181	msyrvania
	rylan	_	10a. State 10b. County	0 1	10c. City, Town o					10d. Inside City Limits
	8a-1 s	cto		George's	Riverda	le Park				1 ☐ Yes 2X No
	vith th	Dire	10e. Street and Number	l D l		10f. Zip Code			10g. Citizen of What Co	untry?
	eath v	eral	5012 Ravenswood		lent Ever in U.S.	20737		in 2 / Sanada, Van an Na	U.S.A.	2000 10 0000
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 ie marked other then "naturel", or Items 23s or 28s-1 show or other traumatic event, the Mayleal Examiner must be notified at	by Funeral Director	1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	Armed Ford	ees: 1945-46	If Yes, specify C		in? (Specify Yes or No- Puerto Rican, etc.)	Black, White	
0-0	72 ho	Completed	15. Decedent	s Education	16a. De	cedent's Usual Occ	supation	-6	16b. Kind of Business/	
21	thin 7	nple	(Specify only highest	College (1-4	4or 5+)	ive kind of work dor a. DO NOT use reti	ired)			
2	ygien ygien ner th		·-		gene	ral contr		self emp.	constructi	on
and	should be filed nd Mental Hygi marked other imatic event, I	Be	17. Father's Name (First, Middle, L Theodore Wi	,				's Name <i>(First, Middl</i> e. Wanda Bonde		
Ë	hould d Me mark matic	ဥ	19a. Informant's Name/Relationsh	in (Tune Print)	10h M	iling Addrage (Stra			r, City or Town, State, Z	ii- C- d-1
Ma	nd 2 s lth an 27 ie i traus		David Wilks - s			-		Market, MD		ip Code)
<u>5</u>	s 1 ar f Hea item	- 6	20a. Method of Disposition		20b. Place of Di	sposition (Name of		Date Date	20c. Location - City or	Fown, State
Ë	Page lent o nt: If ry or		1 Burial 2 □ Cremation 1 Donation 5 □ Other (Sp	3 □Removal from St ecify)	iaie i	rematory or other p rans Ceme	-	/5/2005	Rocky Gap,	MD
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 le any injury or other trau		21. Signature of Funeral Service L		601	22. Name and Add			Funeral Ho	
<u> </u>	8978		a//vine	W. Har	12000	11802 Lib	erty Ro	. Liberty	town, MD 21	
	Physician /Medical		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Att	ed the death. Do not	enter the mode of d	lying, such as c	ardiac or respiratory are	rest,	Approximate Interval Between Onset and Death
	Examiner				as a consequence or).					
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	r as a consequence of).					
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	be exectan a		resulting in death) Last	Due to (or	r as a consequence of):					
187	ate hys	dicai	·	d						
P.O. Box 6	The law requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birt	nt at time of death	3□Ectopic pregnar 5 □ Other (s <i>pecify)</i>			23d. Date of dela Month	very Day Year
	ires that signed b	by	Part II. Dther significant condition	s contributing to dea	th but not resulting in the	underlying cause (given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Division of Vital Records,	w require been si should	Completed								
Rec	has ge 2 a	dm						24a. Was a autop:	sy prior to c	opsy findings available ompletion of cause of
ā	icien: The certificate hare rector, page	e Co	25. Was case referred to medical				00.01	1 Yes	2□No 1□Yes	2□ No
5	Physicien: r this certifica ral director, p	To B	examiner?	Hospital:	oatient 2 ER/Outpa	ient 3 DOA		of Death Check onl or	ence 6 🕅 Other (Spec	to at scope
O	ding Phys		27. Mann of Death	28a. Date of		of 28c. In	jury at	28d. Describe h	ow injury occurred	m at scelle
io	Attending ir death. ector: After by the fune	atio	1 atural 5 Pending 2 Accident investiga	ation	Day rear) Injur		Yes 2 N	0		
Ξ	F in the F	Certification;	3 Suicide 6 Could no 4 Homicide determin	and 286. Place of	f Injury - At home, farm, g, etc. (Specify)	street, factory, offic	е	28f. Location (S City or Town	treet and Number or Rui n, State)	al Route Number,
	urs af	Ce								
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the b xaminer: On the bas and manne	is of examination and/or	ath occurred at the investigation, in my	time, date and opinion, death	place, and due to the coocurred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier	n ()	4	29c. Lice	nse number	2	29d. Date signed (Month	Day, Year)
			Mayone	1 meyo	ule M	0.0	.M.E.		January 1,	2005
	13×111		30. Name and addrest of person w	ho completed cause	of death (Item 23a) (Typ		n Stree	et, Baltimon	re, Marylan	d, 21201
	Sta		31. Date filed (Month, Day, Year)		nistrar's Signature					
	Registr	ar	JAN 0	4 2005	losur K	Sparke				

		1	For State Registrar	State of Ma	aryland .		irtment o				jiene leg. No.	005	01301
	F . S		Decedent's Name (First, Middle, Last,							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic	al	JOHN WILHELM							1	7	2005	12:10 A M
	Examin	er	4a. Facility Name (If not institution, give		_			n, or Location	of Death			County of Death	1
	F		Chester River Heal 5. Social Security Number 6. Se	x 7. Age	l e (in yrs. last		Cheste:	ear If Unde		8. Date of Birth	Ker	9. Birth	nplace (State or Foreign
	Funeral Director	-	058-16-1418	M 2□F	84	Yrs.	Months Da	ys Hours	Min.	(Month, Day 6 27	192		elton, PA
7			Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits
2	shov	5	MD Kent		,	terto							1X Yes 2 □ No
9	28a-1	rect	10e, Street and Number				10f. Zip Co	ie			10g. Citiz	en of What Co	untry?
de la cieta	3a or	Funeral Director	200 Morgnec Road				2162	0			U.S	.A.	
100	ms 2	nera	11. Marital Status	12. Was Decedent Agned Forces?	Ever in U.S.	13. \	Was Decedent 1 Yes, specify	of Hispanic O	rigin? (Spec	ofy Yes or No- lican, etc.)	1	4. Race - Amer Black, White	
0	or Ita	by Fu	Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 1 Il Yes, Give Year or Dates: 2	No 2/16//		1□Yes 2🖔					Specify: Wh	ite
CUO-CIZIZ	tural'	q pa	15. Decedent's Edu			16a Decer	dent's Usual O	cupation			16b. Kin	d of Business/l	Industry
0	n "na n "na Medic	piet	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5		(Give life.	kind of work d DO NOT use re	one during mo atired)	st of workin	9			
7	giene ar tha	Completed	12	College () vol e		Tool	& Die					craft	
yland	d othe	Be (17. Father's Name (First, Middle, Last)						her's Name a Ross	(First, Middle,	Maiden S	Sumame)	
yla	Men Marke Marke	2	John Wilhelm 19a. Informant's Name/Relationship (T.	una Printi	_	10h Mailir	ng Address /Si				r City or	Town, State, Z	(ip Code)
Mai	th and 17 is n traun		Cathy Marketto /							nolia,			
ē.	f Heal	Ì	20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name o	of place)	Jan. 1	ate		cation - City or	
Ê,	Page nent of nt: If		1 ☐ Burial 2 🕅 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1		nation			10,05	Whea Smyr	tley's na. Del	Pond Rd. aware
Baitimore,	permit. Pages 1 and 2 should be lifed within 7 a hours after beath with the maryanic Department of Health and Mental Hydiene. Department of Health and Mental Hydiene. But injury or other traumatic event, the Medical Existing or institute a notified at ODGs.		21. Signature of Funeral Service Licens	Ten Mo 13	375	Mi 1	Name and A 175 S.	deress of Fac Amb State	ruso E Street		Dir	ector,	
25	o E		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death.	Do not ent	ter the mode of	dying, such a	s cardiac or	respiratory ar	rest,		Approximate fnterval Between
1	nysician		Immediate Cause (Final disease or condition		mon	tia	(AI	zhen	Mor	5)			Onset and Death
	/Medical Examiner	1	resulting in death)	Due to (or as	a conseque	nce of):				-			
1 8	- Xammer ;	7	Sequentially list conditions,	b. Due to (or as	a conseque	nce of):							
	be sit	Exar iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,								
ĵ	be execu	Еха	that initiated events resulting in death) Last	Due to (or as	a conseque	nce ol):							
	y s	ical	(d									
99		Med	IF FEMALE:	23c. If ves. outcome	of prognance	m.,			<u></u>			23d. Date of del	ivon
Box	attend attend for us	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant a	2 Fetal d	eath 3[☐Ectopic pregr ☐ Other (speci				-	Month Month	Day Year
o.	the de y the sched	ysic	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown						_			
ď.	res that the death certific igned by the attending p be detached for use as	by Pi	Part If. Other significant conditions of	ontributing to death b	out not result	ing in the u	inderlying caus	e given in Par	11.				the cause of death?
ıdş	w require been sig should b	led t	Hornis							10)	Yes 2	DNo 3□Pr	obably 4 Munknown
Records,	law reas be	Completed	Purkins	ons						24a. Was autop		24b. Were au prior to death?	utopsy lindings available completion of cause of
		Con								1 ☐ Yes	2 3 -No	1 ☐ Yes	2 No
Viital	siclan certifi rector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 TE	R/Outpatie	nt 3□ DOA	Other		(Check only o		5 □Other (Spe	city)
ō	Attanding Physician: ir death. ector: After this certific. by the funeral director.	1	27. Mann of Death	28a. Date of Inju		8b. Time o		Injury at Work?		28d. Describe I			c.i.y)
<u>o</u>	nding F ath. r: After e funer	atlo	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	1	ay rear)	injury	М	1 Yes 2					
Division of	I or Attandated after death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of III	ijury - At hom tc. <i>(Specify)</i>	ne, farm, st	treet, lactory, o	ffice	2	281. Location (S City or Tox			ural Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best niner: On the basis of and manner s	of examination	ledge, dea on and/or in	th occurred at nivestigation, in	the time, date my opinion, d	and place, a leath occurre	and due to the ed at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of pertifier				29c. L	icense numbe	er -		29d. Dat	e signed (Mont	th, Day, Year)
•			1114					1005	188 9	24		1/8/0) 5
			30. Name and address of person who	completed cause of	death (Item :	23a) (Type	, Print) Vain	St (50/01	na n	10	216	35
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 1 1 200		trar's Signatu	Ire A							

			For State Registrar	tate of Maryland	_	artment of h			jiene 2005	01302
	Physici		Decedent's Name (First, Middle, Last)			EEKS		2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give stree ST. AGNES HEALT			4b. City, Town, o	MORE I	th	4c. County of Deat	
	. Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Day	Year) Co	ARYLAND
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MARYLAND		, Town or Lo	cation ORE C	iTY			10d. Inside City Limits 12 Yes 2 □ No
	h with the	Dire	10e. Street and Number 133 NORTH BEND F			10f. Zip Code	_		Og. Citizen of What Co	
36	hours after death with the Maryland turel', or Items 23e or 28e-f show at Examiner must be notified at	by Funeral	11. Marital Status 12. 1 Never Married 2 Married	Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub 1 ☐ Yes 250 No		Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: B	
21215-0036	n 72	Completed t	15. Decedent's Educati (Specify only highest grade co	on	(Give life. L		pation during most of wo d)	orking	16b. Kind of Business/	Industry
	be filed ital Hyg od othe event,	Be	17. Father's Name (First, Middle, Last)	20 10155		IONE	18. Mother's Na	me (First, Middle,		
Maryland	d 2 should be th and Mental 7 is marked of treumatic eve	2	ANTHONY HOW 19a. Informant's Name/Relationship (Type, MOTHER ANTA)	Print) INFE			and Number or R	ural Route Number	r, City or Town, State, Z	
Baltimore,	Pages 1 and nent of Health nent of Health out: If Item 27 ury or other tr		20a. Method of Disposition Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	CE	emetery, cren	sition (Name of	ce)	Date	20c. Location - City or BALTIMORE	Town, State
Balti	permit. Page Department of importent: if any injury or once.		21. Signature of Funeral Service Licensee	per Sue Ly	22	. Name and Addre	ess of Facility 5	T AGNE	MORE, MD	ARE
	Physician	9 ii	23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	ause on each line.		DEL()	1 - 10-1	c or respiratory arr	est,	Approximate Interval Between Onset and Death
8760,	Medical Examiner ohysician and the prival-transit	al Examiner	Sequentially list conditions, Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a))).	(PET	ENT	CERV	ıχ		LNKNOWN
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnand Other (specify)	у		23d. Date of deli Month	very Day Year
rds, P	w requires that been signed to should be deta	by	Part II. Other significant conditions contrib	outing to death but not resu	ulting in the ur	nderlying cause gr	ven in Part I.	23e. Did to	bacco use contribute to	
Il Records,		Completed						24a. Was a autops perfor	sy prior to o med? death?	topsy findings available completion of cause of
on of Vital	ing Physic	tlon; To Be	27. Manner of Death 1 Natural 5 Pending	pital: 1 Xinpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inju	her: 4 Nursing		ne) ence 6 Other (Specow injury occurred	rify)
Division	el or Attending s after death. Il Director: After id in by the fune	Certification:	a Ta : : : 6 T Could get be	28e. Place of Injury - At he building, etc. (Specify		eet, factory, office		28f. Location (S City or Town	treet and Number or Ru n, State)	ral Route Number,
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in It	edical	(Check only 2 Medical Examiner	an: To the best of my kno: On the basis of examinal and manner stated.	tion and/or inv	vestigation, in my	pointion, death occ	urred at the time of	late and place, and due	to the cause(s)
	To the within 2 comple	Σ	29b. Signature and title of certifier	2		29c. Licen	se number +4 152		19d. Date signed (Month JANUARY	Z, 2005
X	.13.41		29b. Signature and title of certifier PF 30. Name and address of person who comp MICHAELP 31. Date filed (Month, Day, Year) JAN 2 0 2005	PARSONS	23a) (Type,	Print) 6400 BA	-TIMORE N	ATTONIAL PIK	E#28 CAT	DNSVILLE, MARYLAND 2122
4	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 0 2005	32 degistrar's Signa	ture	ile				

WERKS, BABY BOY

		For State Registrar	State	of Marylar			of Health		Mental Hyg	iene	005	01303
		1. Decedent's Name (First, Midd							2. Date of Dea Month		Year	3. Time of Death
Physic /Medi		RUTH CI	ROPPER	WITHERS	SPOON	,			Januar		2005	12:53 A ^M
Exami		4a. Facility Name (If not institution	_				own, or Location				ounty of Dear	
		Salisbury 1 5. Social Security Number	Nursing a	7. Age (In yrs.				lisbu ter 24 Hrs.	ry ☑ 8. Date of Birth		icomic	
Funeral Director		230-20-9344 Usual Residence of Decedent	1 M 2 X F		Yrs.		Days Hour		(Month, Day 4/19/1	Year)	9. Bin	hplace (State or Foreign buntry) MD
yland		10a. State 10b. Count	у	10c. C	ity, Town or Lo	ocation						10d. Inside City Limits
Mar a-fst	ctor	MD Wi	icomico		Salisbu	ıry						1 X Yes 2 □ No
or 28	Funeral Director	10e. Street and Number				10f. Zip (Code		1	0g. Citize	n of What Co	ountry?
ath w	rai	1207 Brittin					21801				SA	
er de Itami	une	11. Marital Status	Armed	ecedent Ever in U Forces?	J.S. 13.	Was Decede If Yes, specif	ent of Hispanic of Ty Cuban, Mexic	Origin? (Sp can, Puerto	pecify Yes or No- Rican, etc.)	14.	. Race - Ame Black, Whit	
irs aft	by	1 ☐ Never Married 2 X Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes,	s 2 No Give r Dates:		1 ☐ Yes 2	No Speci	ify:		S	pecify: W	hite
ified within 72 hours after death with the Maryland Hygiene. Hygiene. Whar than "natural", or Itams 23a or 28a-f show ant, the Medical Examinat must be notified at	ted		nt's Education		16a. Dece	dent's Usual	Occupation		tion .	16b. Kind	of Business	Industry
thin 7	Completed	Elementary/Secondary (0-12)	est grade complete College	e (1-4or 5+)	life.	DO NOT use	k done during m e retired)	iost or wor	(III)			
ygien ygien f, the	Con	12			Own	er/Op	erator		450		Motel	
be fill by doth	Be	17. Father's Name (First, Middle							ne (First, Middle, i		ımame)	
2 should be filed within and Mental Hygiene. Is marked other than reumatic event, the Market	²	Thomas Q. 19a. Informant's Name/Relation			19b Maili	na Address /			Edith Co		own State	Zin Code
2 2 E C =									Salisbu			
permit. Pages 1 and Dapartment of Health Important: If Item 27 any Injury or other tronce.		Erskine With 20a. Method of Disposition	ierspoon	20b.	Place of Dispo	osition (Name	e of	III 3t,			tion - City or	
Page ent of nt: If I		1 X Burial 2 ☐ Cremation 1 4 ☐ Donation 5 ☑ Other (AIII ŞIGLE			ial Park	i č 1 /!	5/05	Rer	lin, M	D
rait.		21 Signature of Faneral Service	e Licensee						bage Fu	o mal	Homo	
Depa Impo		1 Mick	Tola	le		108 WI	Illiam S	tBe	rlin. ML	21	811	
		23a and t. Filter the district, construction and the state of the stat	or complications ma st only one cause o	t caused the dea n each line.	th. Do not en	ter the mode	of dying, such	as cardiac	or respiratory arr	est,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	_ a. ()	Con	207	age	en X	Jus	1ase			Onset and Death
/Medical Examiner		resulting in death)	Due	to (or as a cons-	guence of):	1001						
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due	to (or as a conse	gu nce n:	Seul-	25					
uted s nsit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<	•								
exect an and rial-tra	Exa	resulting in death) Last	Due	to (or as a conse	quence of):							
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ledicai		d									
death certifica	Med	IF FEMALE:										
ath ce	Physician/M	23b. Was decedent pregnant in the past 12 months?	1□Liv	outcome of pregn e birth 2 ☐ Fet	al death 3	⊒Ectopic pre				230	d. Date of del Month	ivery Day Year
the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		egnant at time of o sknown	death 5[Other (spe	cify)			1)		,
w requires that the death cer been signed by the attendir should be detached for use		Part II. Dther significent condition	ions contributing to	o death but not re	sulting in the u	inderlying ca	use given in Pa	rt I.	23e. Did tol	acco use	contribute to	the cause of death?
uires uires Isign	d by								1 🗆 Ye	s 2 🗆 i	No 3□Pr	obably 4 Dunknown
w requir been s should	Completed								24a. Was a	n 2	24b. Were au	topsy findings available
vical nec sician: The law s certificate has b lirector, page 2 s	mo								autops	۷ ا	prior to death?	completion of cause of
lan: lan: rtifica	O	25. Was case referred to medic	al				26. Pia	ace of Dea	1 ☐ Yes 2 th (Check only on		1 103	20140
nysici nis ce direc	To B	examiner? 1 Tes 2 No	Hospital:	☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DOA	Other: 4	Nursing H	ome 5 Reside	nce 6	Other (Spec	cify)
ding Phys		27. Manner of Death 1 Natural 5 ☐ Pend		ite of Injury Ionth, Day Year)	28b. Time o Injury	of 28	c. injury at Work?		28d. Describe ho	w injury o	ccurred	
tendi teath. tor: A	cat		tigation	- / h :		М	1 Yes 2	□No	006 1			-10
ior At after of Dirac	Certification:		mined 286. Pie	ace of Injury - At hill illding, etc. (Speci	nome, rarm, st ify)	reet, factory,	Office		City or Town		umber or HL	ıral Route Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 12 Certify	ing Physicien: To	the best of my kn	owledge, deat	h occurred a	t the time, date	and place,	and due to the ca	iuse(s) an	d manner as	stated.
the Ho in 24 the Fu	Medical	one)	ard of	basis of examin anner stated.	ation and/or in				red at the time, d	are and pla	ace, and due	to the cause(s)
Mith To 1	Z	29b. Signature and inter of cent	10/			29c.	License number	er	2	9d. Date s	igned (Monti	h, Day, Year)
		V V /V	18 Van	7			1257	49		11	1/05	
H つ		30. Name and address of perso William Rok					Salisbur	· V AA	D 2180 ¹	1 /	/ /	
) I I O	atė	31. Date filed (Month, Day, Yea		2. Degistrar's Sign			Jansbul	y , 1VI	2100			
Regist		IAN O	5 2005	A.	KA	mant s						

			State of Mar State amended#10b,a,22perf	yland / Depa uneralbom <i>Cel</i>	artment of Health and leaffiched of Death	Mental Hygie m01705705	ene . No. 2005	01304
	Dhysisi	an.	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Lena L		Wilkins	January		1:20 A ^M
	Examir	er	4a. Facility Name (If not institution, give street and number)	,	4b. City, Town, or Location of Death	1	4c. County of Death	1
			Frederick Memorial Hospital 5. Social Security Number 6. Sex 7. Age (Frederick If Under 1 Year If Under 24 Hrs.	9 Date of Birth	Frederi	
	Funeral Director		145-20-9946 1 ■ M 20 F Usual Residence of Decedent	(In yrs. last birthday) 93 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y)	earl Cou	place (State or Foreign ntry) U TLR5 EY
	Maryland -f show	tor		Fred evi	Gaithersbur	g		10d. Inside City Limits 1
	h with the	Funeral Director	10e. Street and Number 9440 Lake Landing Roa	ed	10f. Zip Code 21782	10g	Citizen of What Cou	ntry?
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is merked other than "natural", or Items 23a or 28e-f show or other traumatic event, The Medical Enail wermust be multised at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Every Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert I Yes 2 No Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	14. Race - Ameri Black, White, Specify: BLA	etc.
2	within 72 ho ene. then "netur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	lent's Usual Occupation kind of work done during most of wor DO NOT use retired)	king	b. Kind of Business/In	om e
Maryland 21	2 should be filed withing and Mental Hygiene. is marked other than aumatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Edward Wilkins	77000		ne (First, Middle, Ma	iden Sumame)	
	1 and 2 sho Health and em 27 is ma		19a. Informant's Name/Relationship (Type, Print) John W. Land		g Address (Street and Number or Ru D LEAF Court RO	ral Route Number, C Undallstou		2000)
3altimore,	Pages 1 and nent of He ant: If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposementery, crem Atlantic C	sition (Name of natory or other place) Ty Cem. Jam. 7		c. Location - City or To Hautic City	
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee	22	. N me and Address of Facility Gary	L. Rollin	s Funeral	
	Pnysician /Medical		resulting in death)	1011526	er the mode of dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
	Examiner	1	Sequentially list conditions, b. Due to for as a condition of the conditions of the	The state of the	u'lme			year.
8760,	cate be executed physician and the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C					
9	g phys as the	edlc	d					
O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
Ф	w requires that th been signed by s should be detach	ed by Ph	Part II. Dther significant conditions contributing to death but r	not resulting in the un	nderlying cause given in Part I.	23e. Did tobac	cco use contribute to the	
I Records,		Completed				24a. Was an autopsy performed	d? prior to co	psy findings available mpletion of cause of
Vital	ician: Thi certificate ector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	21 ER/Outpatient	0.1	th (Check only one)		
of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification and the Funeral Director. Completely filled in by the funeral director.	tlon: To	ome 5 Residenc 28d. Describe how	e 6 Other (Specifinjury occurred	y)			
Division	il or Attendi after death. I Director: A d in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (r - At home, farm, stre (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura State)	l Route Number,
	To the Hospital or within 24 hours afte To the Funeral Directional Completely filled in the Funeral Direction of the Fune	Medical C	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check one) Che	kamination and/or inv	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as si and place, and due to	tated. the cause(s)
	within 2 To the	Me	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month,	Day, Year)
	7		30. Name and address of person who complete cause of death SAEEN ZATINI MD 82	th (Item 23a) (Type, I	D43091 Print) buse Ave.	Frederica	k MI)	
	Sta Registr		31. Date filed (Month, Day Near) 5 2005 32. Registrar's	Signature	Grant :			

			1 - For State Registrar	State of Maryland / Dep	partment of Hea ertificate of De		ntal Hygien Reg. N	2005	01305
	Physicia	o m	1. Decedent's Name (First, Middle, Last)				Date of Death	ay, Year	3. Time of Death
	Physicia /Medic		GERALDINE S. WHITI	ING		J	Month)ay 1, 200	5 1:30 A M
	Examin	er	4a. Fecility Name (If not institution, give s		4b. City, Town, or Lo	ocation of Death	1	lc. County of Dea	
_			DOCTORS COMMUNITY 5. Social Security Number 6. Sex		LANHAM v) If Under 1 Year If	f Under 24 Hrs. 8		RINCE GE	
	Funeral Director			7. Age (in yrs. last birthda 3. Age (in yrs. last birthda 1. Age (in yrs. last birthda			Date of Birth (Month, Day, Yea +/04/1920	y) UFC	thplace (State or Foreign ountry) T VIRGINIA
			Usual Residence of Decedent			0-	+/04/1920	WES	I VINGINIA
	ryland how		10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	e Ma	cto	MARYLAND PRINCE GE	ORGES GLENN DAI	E				1 X Yes 2 □ No
	ith th	Dire	10e. Street and Number		10f. Zip Code		10g. C	Citizen of What C	ountry?
	death with the Maryland ms 23a or 28e-f show r must be rodiffed at	Funeral Directo	12012 FAIRWAY COUR		20769		USA		
	er de Item mern	nue	The state of the s	Armed Forces?	 Was Decedent of Hispa If Yes, specify Cuban, ! 	anic Origin? (Specif Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - Am Black, Whi	
	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🔯 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛱 No S	Specify:		Specify: W	HITE
5	2 hou		15. Decedent's Edu		cedent's Usual Occupatio	on	16b.	Kind of Business	
7	hin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	ve kind of work done duri . DO NOT use retired)	ing most of working			
7	ed wil	Con		1 SECRE	ETARY		IN	ISURANCE	
2	be file tal Hy doth svent	Be	17. Father's Name (First, Middle, Last)			3. Mother's Name (F		an Sumame)	
7	ould Men varke	2	RAY SKIDMORE			THELMA HAF			
	12 st h and 7 is n treun		19a. Informant's Name/Relationship (Ty)		iling Address (Street and				
ת ע	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene at fement 23a or 28e-f show frem 21s marked other then "naturel", or frems 23a or 28e-f show other treumatic svent, tra Medical Examiner must be notified at		RUSSELL GARDNER/ S 20a. Method of Disposition	20b. Place of Dis	PAIRWAY CO	OKI GLENN	-	LARYLAND Location - City or	
2	permit. Pages 1 and Department of Health Importent: If Item 27 eny Injury or other tonce.		1 ☐ Gurial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval nom State	ematory or other place) IAM CEMETERY	7 01/07/			ST VIRGINIA
Dalling	nit. P artme orten Injur e.		21. Signature of Furieral Service License		22. Name and Address of				
ğ	Depar Impor eny ir) KUKA		.6000 ANNAPO				
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the death. Do not e				· · · · · · · · · · · · · · · · · · ·	Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition		PAIFILMAN	11.0			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):	TIVEOLION	J//T			011(3)
	Examiner	_	Sequentially list conditions,	Due to (or as a consequence of): PARKINSON	DISEASE	_			YEARSS
	ed isit	Examiner	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	Dus to (or as a sonsequence of).					
	xecut and al-trar	xan	that initiated events resulting in death) Last	Due to (or as a consequence of):					
9	es that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	sai E							
00	ifficate g phy as the	edicai		· -					
XOC.	h cert endin use	M/u	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	Ectopic pregnancy			23d. Date of de	livery
	s deat	sicia	in the past 12 months?		Other (specify)			Month	Day Year
5	at the d by ti etach	Physician/M	9 Unknown						
<u>ה</u>	res the signer	by	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given ii	n Part I.	1 ☐ Yes	/	o the cause of death?
cords,	w requir been si should	etec					.		
ב ב	hast hast	Completed					24a. Was an autopsy performed?	24b. Were at prior to death?	utopsy findings available completion of cause of
VIIAI	n: Th ficate n: pag	e Co	05 Wee and other day of the				1 Yes 2 N	o 1 ☐ Yes	2. No
5	sicie s certi lirecto	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2 ER/Outpati	O++	6. Place of Death C		6 CO 045 /C	
5	ding Physicien: The la h. Affer this certificate has funeral director, page 2	\vdash	27. Manner of Death	28a. Date of Injury 28b. Time	of 28c. Injury at	4 Nursing Home 28d	Describe how inju		city)
NISIOIS NISIOIS	ath. r: Afte	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury		2 🗆 No			
<u> </u>	r Attencer death	ertification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f.	Location (Street a City or Town, Star		ural Route Number,
2	itel o	0							Ţ,
	To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after dors. The control of the theory after dors. The the Fuencial Directors After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knowledge, de- ner: On the basis of examination and/or and manner stated.	ath occurred at the time, of investigation, in my opinion	date and place, and on, death occurred a	due to the cause(at the time, date ar	s) and manner as nd place, and due	s stated. to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier		29c. License nu		29d. D	ate signed (Mont	h, Day, Year)
			I arand Alau	CIN	D0058	275	1-	1-05	
			30. Name and address of person who co	mpleted cause of death (Item 23a) (Type	e, Print)	200000	0.0		
			BIIS GOOD LUCK Re			PARANC	richvi,	CM	
	Sta Registra		JAN 0 3 21	32. Figistrar's Signature	book				

			1 - For State Registrar	State o	f Marylar		artmen rtificate			and M	ental Hyg	iene g. No.	005	01306
	Physici /Medio	al		lizabeth A							2. Date of Deat Month	Day 15	Year 2005	3. Time of Death 05/15 4 M
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	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under	1 Year	If Under 2		8. Date of Birth	1	9. Birtho	lace (State or Foreign
- 1	Director		493-64-4274	1 □ M 2 🖫 F	95	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, May 4, 19	909	Sue (City, MO
	and w		Usual Residence of Decedent 10a. State 10b. Cou		10c. C	ity, Town or L	ocation						1	0d. Inside City Limits
	Maryl -f sho	tor	MO Ma	con		Anab	e1							1 ☐ Yes 2 🗷 No
-	h the	Director	10e. Street and Number				10f. Zip	Code			1	og. Citizer	of What Coun	itry?
	ath wi	ral	38067 US Hig	hway 36				53431				US		
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heath and Mental Hygiene. It has 23e or 28e-f show item 27 is marked other then "natural", or items 23e or 28e-f show other traumetic event, It we Medical Exama we must be notified at	by Funeral	11. Marital Status 1 Never Married 2 N 3 Widowed 4 Divorce	Armed Fo	2 ⊠ No ⁄e		Was Deced If Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto I	cify Yes or No- Rican, etc.)		Race - Americ Black, White, becify: Whi	etc.
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d 2	e filed within the Hygiene. other then went, the My		12 17. Father's Name (First, Midd	fle, Last)		110	Onchia	ICI.	18. Mothe	r's Name	(First, Middle, N	faiden Su	mame)	
lan	lid be fental rkad ric ev	To Be	Albert Lee	Mumford					Laur	a Al	ice Brul	oacke	r	
Maryland	id 2 should be f th and Mental ! 27 is markad of traumetic eva		19a. informant's Name/Relation								na, MD 2		own, State, Zip	Code)
ē,	s 1 and Heal		20a. Method of Disposition	•	20b.	Place of Dispo cemetery, cre			9	an.			ion - City or To	wn, State
m 0	Page nent c ant: # ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Other			plata			" 0	200		Lapla	ta,MO	
Baltimore,	permit. Pages 1 and 2.9 Department of Health at Important: If item 27 is any injury or other trau QDG9.		21. Signature of A neral Serv	ice Licensee			2. Name and Charle 1501 1	es L.	Ste	vens	Funeral Baltim	L Hom	e Inc. D. 2123	30
			23a. Part1. Enter the disease shock, or heart failure.	, or complications that c ist only one cause on e	aused the dea ach line.									Approximate Interval Between
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687	ficate p phys is the	edical		d										
Box 6	eath certific attending pl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn		⊒Ectopic pre	oananou				23d	. Date of delive	ry
	ne deat the att	sicia	in the past 12 months?		ant at time of		Other (spe						Month	Day Year
P.0	that the di led by the detached		9 ☐ Unknown Part II. Dther significant cond	fitions contributing to de	eath but not re-	sulting in the u	anderwing ca	ause awe	n in Part I		23e Did toh	acco use	contribute to th	e cause of death?
ds,	uires t signe Id be	d by						,			1 □ Ye			ably 4 □Unknown
CO	aw requir	Completed									24a. Was ar			osy findings available
Re	The lay	mo									autops perform	ed?	death?	npletion of cause of 22 No
/ita	ysician: Th is certificate director, pag	BeC	25. Was case referred to med examiner?							of Death	(Check only one			
of	Physi this c	To.	1 Yes 2 No	Hospital: 1 XI		ER/Outpatier			4 🗀 14U1		ne 5 Reside			")
on	iding Ph th. : After th funeral	tlon	1 Natural 5 ☐ Per		th, Day Year)	Injury	M	Bc. Injury Work	es 2 □ N		.ou. Describe no	w injury or	Journe d	
Division of Vital Records,		Certification:	3 ☐ Suicide 6 ☐ Coi	uld not be 28e. Place	of Injury - At h	nome, farm, st	reet, factory	, office		2	28f. Location (Str City or Town	eet and N	umber or Rura	l Route Number,
D	ital or irs afte ral Diri													
	To the Hospital or Attan within 24 hours after deat To the Funaral Diractor: completely filled in by the	edical	29a. Certifier 1 Certi (Check only one) 2 Media	fying Physicien: To the cal Examiner: On the ba and man	best of my knoasis of examination stated.	owledge, deat ation and/or in	h occurred a vestigation,	at the time in my op	e, date and inion, de <i>a</i> t	d place, a h occurre	and due to the ca and at the time, da	use(s) and te and pla	d manner as sta ice, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of cert	rfier				. License					gned (Month, L	
	ر کرار		1 ten 4	Mari					741			mo	7 15,	2005
	7-11		30. Name and address of pers	RANCIS (RANCIS	e of death (Ite	m 23a) (Type, VoBH	Print)	-001	_ 1.4.	150	t=1			
	Sta	te	31. Date filed (Month, Day, Ye	par) 32. R	gistrar's Sign	ature	1,100	٠,ر٠	- F/C	J 3/7,	. / ,			
	Registi		JAN 2	1 2005	Roller	15 P	POSEL	4						

	1	For State Registrar	State of	Marylan			of Health a of Death	ind Me		ene g. N.2 () (5 0130
Physiciar /Medica Examine	n 1	I. Decedent's Name (First, Middle Foy L. Allen Ia. Facility Name (If not institution 312 Syria Cour	, give street and numb	oer)			wn, or Location of ashingto	f Death	2. Date of Death Month January	Day 19, 2005 4c. County of	
Funeral Director	5	Social Security Number 232–86–3304	6. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. 92	last birthday) Yrs.	If Under 1 \ Months D	ear If Under 2 Pays Hours	24 Hrs. 8 Min.	Date of Birth (Month, Day, 2/18/19		9. Birthplace (State or Foreig Country) WV
Maryland -f show		Jsual Residence of Decedent 10a. State 10b. County	Fayette	10c. Cit	y, Town or Lo ayette	cation ville					10d. Inside City Limit
3a or 28a	Funeral Director	10e. Street and Number P.O. Box 592				10f. Zip Co	2584	10	10	g. Citizen of W US	
IIS	2	11. Marital Status 1 □ Never Married 2 □ Marri XX Widowed 4 □ Divorced	12. Was Decede Armed Force ed 1 Tyes 2 If Yes, Give Year or Date	es? XXXIo		Was Deceden f Yes, specify 1 ☐ Yes 2	t of Hispanic Orig Cuban, Mexican, Mo Specify:	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	Black	- American Indian, t, White, etc. Black
12 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "natu traumatic event, the Mudical TO BO Complete.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) Unk •		or 5+)	16a. Deced (Give life.	dent's Usual C kind of work of DO NOT use i	done during most retired)	of working	1	6b. Kind of Bus	wn Home
uld be file Mental Hy irked oth itic event	lo pe	7. Father's Name (First, Middle, I Richard Bu	ndrant						First, Middle, M Hopki	laiden Sumame ns	9)
and 2 sho ealth and N n 27 is ma		19a. Informant's Name/Relationsh Foy Booker / Dai					treet and Number Court, F				
t. Pages 1 at the then of He tant: If item		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (St. 21. Signature of Funeral Service I	pecify)	ate Hu		rial Par	of r place) k. Janaury ddress of Facility			Oc. Location - C	City or Town, State
rnysician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	complications that cau only one cause on each a. Conjes Due to (or Hyper	stive	h. Do not ent Hear uence of): ve Ca	501 Fas erthe mode o t Fai		ardiac or r	Baltimore respiratory arre	MD 21230	Approximate Interval Between Onset and Death
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										ed? de	ere autopsy findings availal ior to completion of cause o ath? Yes 2 S
tending Physically. Itor: After this the funeral discontinuous	2	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death Natural 5 Pendin, investig 3 Suicide 6 Could r 4 Homicide	ation of be 28e. Place of	Injury Day Year)		28c.	Other: 4 Nurs	sing Home 28d		nce 6 X Other v injury occurre eet and Number	140.110.01
s afte s afte al Dire		29a. Certifier TCertifyin	g Physician: To the be	est of my kno	wledge, death	occurred at t	he time, date and my opinion, death	place, and	d due to the car	use(s) and man	ner as stated.
Hospi 4 hour Funer ely fill	<u> </u>	(Check only 2 Madical 8				outigation, in					14 444 10 1110 04400(0)
To the Hospital or At within 24 hours after to the Funeral Direc completely filled in by Madical Certiff		29b. Signature and title of certifler	t Henry my	stated.		29c. Li	cense number	5993		d. Date signed	(Month, Day, Year)

500 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 5 900 100 1 - For State Registrar Certificate of Death 5 Reg. No. 36 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 1:30A. M JAN 2005 sobert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Rossville AUOR CARE ROSSVIlle BALTIMORE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days 10 M 2□F 212-62-889 Director MARYLAND Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County or 28a-f ahow Baltimore 1 Yes 2 □ No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 4101 Items 23a HVe 12. Was Decedent Ever in U.S. Armed Forces? . 1 Tyes 2 To 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 22 No ō Specify: Specify: white If Yes, Give Year or Dates: Completed by 3 ☐ Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 1.2 should be filed within 7.2 h and Mental Hygiene. 7 is marked other than "n Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 12 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Ruth Vanko Abell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If Item 27 is any Injury or other tra BALTIMORE, Ave, tranken berger 4101 Wilke MD 21206 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition

1 ABurial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Date Gardens of Faith Cem. Kosedale 4 ☐ Donation 5 ☐ Other (Specify) 1-21-05 22. Name and Address of Facility BALTI MORE, MD 21234. 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, o) complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOXIA Priysician /Medical Due to (or as a consequence of): DAYS Examiner DEHYDRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit DEMENTIA Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ GCIOMA 1 Yes 2 1 No 3 Probably 4 Unknown Completed ENCES HACITIS 24b. Were autopsy findings available prior to completion of cause of death? KADIATION autopsy performed 2 🗆 No 2 4 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Li Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 扰 D55306 n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9106 PHICADELPHIA Juite BALTO DENNIS ·H 1001E 32. Registar's Signature 31. Date filed (Month, Day, Year) State Marken JAN 2 1 2005 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Anderson, Carole

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Ö	w requir been si should	etec	ingeory of ranc	reacte in	100					_	1016	s 2 XIN	0 3 P	Probably 4 Unkn	own
Vital Records,	The lav ate has page 2	Completed									24a. Was a autops perform	y	4b. Were a prior to death?	utopsy findings avail completion of cause	able of
ta		e Cc	25. Was case referred to medical							475.77	1 ☐ Yes 2	No.	1 ☐ Yes		
	Physician: r this certificant ral director,	OB	examiner? 1 Tes 2 No	Hospital:	atient 2 TF	ER/Outpatient	3(7,004				(Check only only only only only only only only		011 11 10		
0	ding Phys h. After this funeral di	n: T	27. Manner of Death	28a. Date of Ir		28b. Time of Injury		c. Injury a Work?	t it	2	8d. Describe ho	w injury oc	curred	Hospic	E
<u>S</u>	Attending r death. ector: After by the fune	atlo	1XXNatural 5 ☐ Pending investigation	n	Day / Ga/)	injury	М		s 2 \square N	0					
Division of	l or Atten after deatl Director: In by the	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	28e. Place of	Injury - At hor etc. (Specify)	me, farm, stre	et, factory,	office		2	Bf. Location (Str City or Town	reet and No	umber or R	ural Route Number,	
	Hospital (14 hours a) Funeral Ditely filled i		29a. Certifier 1 Certifying P	husiais - T		4-4				E					
	# Hos 24 hc Fun etely	Medical	(Check only one) (Check only one)	hysician: To the be miner: On the basis and manner	s or examinati	vledge, death on and/or inve	occurred at estigation, i	the time, n my opir	date and ion, death	place, ar occurre	nd due to the ca d at the time, da	use(s) and ate and place	i manner as ce, and due	s stated. e to the cause(s)	
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	Me	29b. Signature and title of conifier		Juliou.			License r						(h, Day, Year)	
			VI Allann	L			\wedge	4/	121	a		011	001	26	
	1	-	30. Name and address of person who							0		/	-1/0	ノフ	
	U		Charles Harriso	n. M.D.:				.11 R	d., 1	Rock	ville, l	MD 2	0852		
a	Stat Registra	State 31. Date filed (Month, Day, Year) 32. Sgistrar's Signature													

			1 - For Stata Registrar	State of Maryland			lealth and I	Mental Hygi	ene 2.005	01312
	Physici /Medio		1. Decedent's Name (First, Middle, Last) HAROLD BU	MD				2. Date of Death Month	Day Year	3. Time of Death 4:00 PM
	Examir Funeral	ier	4a. Facility Name (If not institution, give : JOHNS HOPEINS BY VII 5. Social Security Number 6. Sex	on med-lenie		BALTIM!	If Under 24 Hrs.	8. Date of Birth	4c. County of Dea	rthplace (State or Foreign
	Director		Usual Residence of Decedent	M 2□F 49	Yrs.	Months Days	Hours Min.	Augusty		MD
	the Maryla 28a-f shov	Director	MD NA 10e. Street and Number		timor			10	g. Citizen of What C	10d. Inside City Limits 1 X Yes 2 □ No
36	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-1 show ta Madical Execution must be notified at	by Funeral Dir	4103 Mountwood	Road 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 [No If Yes, Give Year or Dates:		21	229 lispanic Origin? (Sl an, Mexican, Puert Specify:		U S 1 14. Race - Am Black, Wh Specify:	encan Indian,
21215-0036	a within 72 hou jiene. r than "natura ine Modical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give	OO NOT use retired	during most of wor. d)	king	6b. Kind of Business	s/Industry
and 2	be filed ital Hygi id other avant, I	Be	12th grade 17. Father's Name (First, Middle, Last) Jesse D. Bland	na		Painte	18. Mother's Nam	ne (First, Middle, M Matthew		oloyed
Maryland	d 2 should be and Menta to and Menta 7 is marked traumatic and traumatic and the and traumatic and the	은	19a. Informant's Name/Relationship (Ty	ре, Print)	19b. Mailin	g Address (Street			City or Town, State,	Zip Code)
	ges 1 and of Healt It itam 2		Thelma Bland-MO 20a. Method of Disposition 1 Ma Burial 2 □ Cremation 3 □ R	emoval from State	ace of Dispo emetery, cren	sition (Name of natory or other plac	ce)	Date 2	Oc. Location - City of	
Baltimore,	permit. Pag Department Important: I any Injury o		'4 □ Donation 5 □ Other (Specify) 21. Signature of Fu ral Service License	MD Per K Dames	/ Ma	Name and Addres	ss of Facility West		Laurel	
	Fnysician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	. Do not ente	mi//h/	g, such as cardiad	Baltim or respiratory arres	Ore, Ma	Approximate Interval Between Onset and Death
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be defached for use as the burial-transit	ilcal Examiner	Sequentially list conditions, it is any less ling to irrelate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ						
.O. Box 6	it the death certifice by the attending pt tached for use as tt	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
Δ.	w requires that been signed b should be deta	by	Part II. Other significant conditions con	tributing to death but not resu	lting in the ur	nderlying cause giv	en in Part I.		/	the cause of death?
al Records,		Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of s 2 \(\square\$\) No
·Vital	Physician: T this certificat ral director, pa	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ER/Outpatien	t 3 DOA Oth	0.00	th <i>(Check only one,</i>	ce 6 □Other (Spe	acifu)
ion of	ling After une	atlon; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injun Worl		28d. Describe how		iony
Division	ital or Attand irs after death ral Diractor: led in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in the Funeral Director Complet	Medical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examir one)	sician: To the best of my knowner: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
)	To the within 2 To the complet	Σ/	206. Signature and title of certifier	MD		29c. Licenson	- 000	290	Date signed (Moni	11 1 10 10 1
1	5-11		30. Name and address of person who co	mpleted cause of death (Item BM NM/WE	23a) (Type, 1	21224	ATTN: 1	VEWDU E	ENNAT	MD
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 1 200	32 Alegistrar's Signati	ure	de	•	J	1	

	_	For Stata Registrar	State of Ma		Department of Certificate of		Mental Hy	giene Reg. No.	2005	01313
Physici		1. Decedent's Name (First, Middle,	Bryan				2. Date of Do Month	Day	Y 200	3. Time of Death
/Medic Examin		4a. Facility Name (If not institution,	give street and number)	(1		or Location of Dea		/	County of Death	-
Funeral		5. Social Security Number		e (In yrs. last bin		r If Under 24 Hr		rth	9. Birth	Tolace (State or Foreign
Director		216-64-7366	1 €M 2 □ F	- 1 -	Yrs. Months Day	s Hours Mir	8. Date of Bi (Month, D.		57 Mary	nplace (State or Foreign Intry) Land
yland tow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Location					10d. Inside City Limits
ne Mar Ba-fsh	Director	Maryland N/A		Baltimo						1 X Yes 2 □ No
ine, intally failed K. I.K. I.S. DOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOO	i Dire	10e. Street and Number 1522 Mc Henry St	reet		10f. Zip Code 2122				zen of What Cou I States C	of America
or death	unera	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Decedent of If Yes, specify Cu		Specify Yes or Norto Rican, etc.)	0- 1	4. Race - Amer Black, White	ican Indian,
urs afte	Completed by Funeral	1 Never Married 2 Marrie Married 2 Marrie Midowed 4 Divorced	d 1 ☐ Yes 2 X1 If Yes, Give Year or Dates:	No	1 □ Yes 21/2 N				Specify: Wh	
72 ho	eted	15. Decedent's (Specify only highest	Education grade completed)	16a.	Decedent's Usual Occ (Give kind of work don life. DO NOT use retii	upation e during most of w	orking	16b. Kin	nd of Business/li	ndustry
d within jiene.	dwo	Elementary/Secondary (0-12) 12	College (1-4or 5	5+)	Self-emplo			ment	Const	ruction
II y I all I a a le should be filed within and Mental Hygiene. marked other than matic event, IDE M.	Be	17. Father's Name (First, Middle, L Harry Paul Bryan				1	ame (First, Middle	, Maiden S	Sumame)	
2 should be filed with and Mental Hygiene. Is marked other than summatic event, the	은	19a. Informant's Name/Relationshi	·	196.	. Mailing Address (Stree		a Watts Rural Route Numb	er, City or	Town, State, Zi	ip Code)
and 2 s and 2 s ealth ar m 27 is	8	Barbara Channell	, Mother	15	22 McHenry	Street, B		-		
85= 5		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Special Control	3 □Removal from State		Disposition (Name of y, crematory or other po		Date O / O F		cation - City or T	
partition permit. Pages Department of Important: If it any Injury or o		21. Signature of Funeral Service Li		Green	ount Cremat 22. Name and Add				imore,Ma Services,	
Dermi Depa Impo any le		Itali	200			h Stricker			e, Maryl	
Physician		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final	omplications that caused nly one cause on each lii	i the death. Do r ne.		ving, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
/Medical Examiner		disease or condition resulting in death)	Due to (or as	a consequence		nona				
	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	of):					
oculed.	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с							
ofou, cate be exemply sician a		resulting in death, Last	Due to (or as	a consequence	of):					
as as	Medical	IF FEMALE:								
eath ce attendii	hysician/N	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		2	3d. Date of deli-	very Day Year
that the death cer ed by the attendin detached for use	Physi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
w requires that been signed to should be detailed.	by	Part II. Other significant condition	s contributing to death b	ut not resulting in	the underlying cause o	iven in Part I.		tobacco us Yes 2□		the cause of death?
law requires as been sign 2 should be	ompleted						24a. Was		24b. Were aut	opsy findings available
	Com						auto perf	ormed? 2 4 No	death?	ompletion of cause of 2□ No
99 (0.22	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	- ent 2□ER/Ou	tpatient 3 DOA	26. Place of Dether: 4 \(\sum \) Nursing	eath (Check only		Cother (Core	× .
ng Phy Ifter this	-	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju	ry 28b. T	ime of 28c. In		28d. Describe			19)
Attanding r death. actor: After by the fune	ficati	2 Accident investigation inves	ot be	urv - At home, la	M 1 [Yes 2 No	281 Location	(Street and	d Number or Ru	ral Route Number,
LINI tal or At rs after d al Dirac! ed in by	Certification:	4 Homicide determin	building, et	c. (Specify)				wn, State)		a
To the Hospital or Attandi within 24 hours after death. To the Funaral Director: A	edicai	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminar: On the basis o and manner st					cause(s) a date and	and manner as place, and due	stated. to the cause(s)
To the vithin To the comple	Me	29b. Signature and title of certifier	LPS	1	29c. Lice	nse number	3		signed (Month	
		30. Name and address of person w	tho completed cause of co	looth (transcari	Tugo Brita	0529	00	Jan	wary !	4, 2005
		Lamont C	, Smith	h E	on se	cursy	4050			
Sta Registi		31. Date filed (Month, Day, Year)		ar's Signature	gype, Print) Sel	7	,			
DHMH 17 Rev 1/2		47117 D I	2000	W JU	The same of					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 19, Ellen N. 2005 3:45AM [™] /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Sykesville 3860 Sykesville Road Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan 21, 9. Birthplace (State or Foreign Country) **Funeral** 1□M 2∏F Days Hours Min 215-20-8015 79 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any highry or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3860 Sykesville Road 21784 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1□Yes 2√ No þ Specify: Specify: White 3 □XVidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Nurse's Aid Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Benjamin Noyes, Sr. Margaret Ellen Ware 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sue Ellen Fritz (Daughter) 2908 Sterling Point Dr., Portsmouth, VA 23703 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Temation 3 Removal from State 4 Donation 5 Other (Specify) All County Cremation 1/24/2005 Sykesville, MD 21. Signature of Funeral Service Licensee 2. Name and Address of Escilly
HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195)
Sykesville, MD 21784 (410)-795-1400 suar 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Stage **Physician** znd 2003 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No detached 9 Unknown 9 Unknown 3 s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Alzheimen Demeutic 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 autopsy certificate 1 Yes 2**V** No To the Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 ☐ Nursing Home Certification: To 2 ER/Outpatient 3□ DOA 5 Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural Injury 5 Pending investigation within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) H50714 9/05 701 npleted cause of death (Item 23a) (Type, Print) 1380 Progress Way Yamela. Pickrel Pac MD a116 -31. Date filed (Month) 2. Registrar's Signature State Registrar

	State of Maryland / Department of Health and Mental Hygiene 1 - State Amend Item 10b-c per fh G839 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) Physician 2. Date of Death Month Day Year 3. Time of Death Month Nonth Day Year													
				2. Date of Deat	h	3. Time of Death								
			Irene Banks	Month D /	Day Year	5 05:15 AM								
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De		4c. County of De									
			Johns Hopkins lare (benamics) lenter Bultimore, &	10	Baltu.	City								
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	in. / (Month, Day,	Year) 9. Bi	rthplace State or Foreign ountry)								
	Director		Usual Residence of Decedent	Nov. 3, 1	910 Ma	iryland								
	land		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits								
	Mary	ţō	MD NA Baltimore Baltimore Catonsville			1 Yes 2 No								
	r 28a	rec	10e. Street and Number 10f. Zip Code	10	Og. Citizen of What C	Country?								
	23a o	a D	4 Winesap Ct. Apt. E 21228	t	ISA									
	dea	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Am									
36	or its	F.	1 Never Married 2 Married 1 Yes 2 WNo	erto ritoari, etc.)	Black, Wh	ite, etc.								
215-0036	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show the Medical Examinat must be codified at	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:			lack								
15-	n 72 nat	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of wife. DO NOT use retired)	working	16b. Kind of Busines:	s/Industry								
212	withi iene. than	mc d	Elementary/Secondary (0-12) College (1-4or 5+)	Į.	Private +	tome.								
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an	lid be lental rkad o	ToB	John Tucker Annie	Smith	Son									
Maryland	S should be and Mental is markad o sumatic eva		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Number,	City or Town, State.	Zip Code)								
	1 and 2 Health a Health 27 is		Eunice Tycker 14 Winesap Ct. Ap	it. E Cato	nsville, m	10 21228								
ore	of He of He fitem		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 2	20c. Location - City o	r Town, State								
Ĕ	Pages ment of I ant: If its ury or o		· 4 Donation & Other (Specify) Sing Memorial Park 1-	21-05 R	andallsto	wn, MD								
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparment of Health and Manial Hygiene. Importants if item 27 is marked othat than "natural", or Items 23a or 28a-1 show arry higher traumatic event, the Medical Evandrat must be notified at any higher othat traumatic event, the Medical Evandrat must be notified at ance.		21. Signature of Fyneral Service Licensee 22. Name and Address of Facility			21229								
_	20539		Gary P. March Fly	270 Fredh	ilton Pass	Balto mo								
г			23a. Party Eyler the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock or heart failure. List only one cause on each line.	lac or respiratory arre	st,	Approximate Interval Between								
	Physician		Immediate Oause (Final disease of condition resulting in death)			Onset and Death 400 KS								
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8760,	cate be executed physician and the burial-transit	dlcal	d											
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Вох	leath certifici attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of de									
Э. Е	e dea he att	Physician/Me	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year								
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of	Phys r this ral di	. To	1 Yes 22 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 Nursing 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	Home 5 Reside		ecify)								
O	ding F th. After funer	tlor	1 Anatural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	254. 2555,155 115	wilding coodings									
Division	after deatl after deatl Diractor: in by the	flca	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		eet and Number or R	ural Route Number,								
Ö	al or	Certification;	4 ☐ Homicide determined building, etc. (Specify)	City or Town	State)									
	pspits hours unera y fille		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla	ce, and due to the ca	use(s) and manner a	s stated.								
	To the Hospital or Attending within 24 hours after death. To tha Funeral Diractor: After completely filled in by the funer	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death oc and manner stated.											
	To t To t	Σ	29b. Signature and tine of certifier 29c. License number	29	d. Date signed (Mon	th, Day, Year)								
•	\sim		MS 20060052	96	117/05									
	, 7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Canha E	2 14 .	0 010-11								
			31. Date liled (Month, Day, Year) 32. Plaistrar's Signature	care f	Patto. N	1) 01024								
	Sta Registr		29b. Signature and time of certifier 29c. License number 20c. License											

			For State Registrar	State of Mar		artment of rtificate o	Health and M f Death		Reg. No 20	05	01316
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) . MARJORIE W. BUT	TLER				2. Date of Dea Month JANUARY	Day	Year	3. Time of Death 5:10 A M
	Examin		4a. Fecility Name (If not institution, give stru SUBURAN HOSPITA			4b. City, Town BETHE	, or Location of Death ESDA		4c. County MONT	of Death	RY
	Funeral Director		220 02 0103	7. Age (In yrs. last birthday 85 Yrs.	Months Day		8. Date of Birt (Month, Day JAN. 28,	1919	9. Birthp. Coun GEO	lace (State or Foreign try) RGIA
_	show	or	Usual Residence of Decedent		Oc. City, Town or L BETHE					10	0d. Inside City Limits 1XXYes 2 □ No
	death with the Maryland rms 23a or 28a-f show r must be notified at	Direct	10e. Street and Number 10306 ROSSMORE			10f. Zip Code	0814		10g. Citizen of V	/hat Coun	itry?
9	ie ite	Funeral Director	11. Marital Status 12 1 □ Never Married 2 □ Married	. Was Decedent Eve Armed Forces? 1 Tyes 2 XNo	er in U.S. 13.		f Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		k, White,	an Indian, etc. HITE
Maryland 21215-0036	in 72 hours n "natural", Aedical Exe	Completed by	3 Dividowed 4 Divorced 15. Decedent's Educa (Specify only highest grade of	completed)	(Giv	edent's Usual Occ		ing	16b. Kind of Bu	siness/Inc	
1d 212	e filed with Il Hygiene. other thai	മ	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	Coilege (1-4or 5+)		SCH00L	TEACHER 18. Mother's Name				
arylar	should be and Menta s marked umatic ev	ToB	ROBERT L. PHII		19b. Mail	ing Address (Stre	VER/	A HARREI		State, Zip	Code)
lore, M	ges 1 and 2 at of Health a if item 27 I or other tra		BARBARA GREENSTRE		20b. Place of Disp	osition (Name of ematory or other p	Or il tor t	Date RY	A, MD 20 20c. Location - FREDERIO	City or To	
Baltimore,	permit. Pa Departmer Important any injury once.		21. Signature of Funeral Service Licensee	Decare	REST CEME	12. Name and Add BROWN FUNE	21, Tress of Facility RAL HOME, P.	2005 O. BOX 82 INSBURG,			
	Enysician		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final	tions that caused the cause on each line.	142000	inter the mode of d	lying, such as cardiac				Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)	Due to (or as a c	•	12010					
Kt.	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a c	consequence of):						
09289	certificate be oding physicialse as the buri	licai	d.						-	-	
, O. Box	death e atter ed for u	hysician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	□Ectopic pregnar □ Other (s <i>pecify)</i>			23d. Dat Mor	e of delive nth	ny Day Year
BUTLER SIOAM Records, P.	w requires that the been signed by th should be detache	by P	Part II. Other significant conditions contr	ibuting to death but	not resulting in the	underlying cause	given in Part I.		_		ne cause of death? ably 4 □Unknown
.47	aw is b	Completed						24a. Was autop perfo 1 \(\subsection \text{Yes}	rmed?	rior to cor leath?	osy findings available inpletion of cause of
Vital V	cian: ector,	Be	25. Was case referred to medical examiner?	spital:			26. Place of Deat				
11 N 2	Physic ruthis cral dir	To.	1 Yes 2 No	Impatient	2 ER/Outpatie		Other: 4 \sum Nursing Ho		lence 6 Othe		/)
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	nding tth. :: Afte e fune	ation	1-☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day)	'ear) Injury	V	Vork? □ Yes 2 □ No		. ,		
ARJ 118 Divis	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, s (Specify)	treet, factory, offic	ce	28f. Location (5 City or Tox	Street and Numbern, State)	er or Rura	l Route Number,
Σω	ths Hospi nin 24 hour the Funer npletely fill	edical	29a. Certifier 1 Certifying Physic (Check only one) 1 Medical Examine		xamination and/or i	nvestigation, in m	y opinion, death occur	red at the time,	date and place, a	and due to	the cause(s)
	/	M	29b. Signature and title of certifier	0/3	n pr	D D	00 5 7/		29d. Date signed		
	り		30. Name and address of person who com TRUONG BAO, MD, 1321				RMANTOWN, MD	20874			
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 1 200	32. Raistrar		hats					

DHMH 17 Rev 1/2001

JANUARY

LAWRIENCE BURKMAN

			For State Registrar	State of Marylan		artment of Hetificate of L		Mental Hy	giene (05	01318
	Physici	_	Decedent's Name (First, Middle, Lucia	_{Last)} Brodsky				2. Date of De Month Januar	-	2005	3. Time of Death 6:25AM
ı	/Medic Examin		4a. Facility Name (If not institution,	give street and number) th Care Larkin C	haco	4b. City, Town, or Bowie		ath	4c. Coun	ty of Death	
	Funeral		5. Social Security Number	6. Sex 7. Age (In yrs. i		if Under 1 Year	If Under 24 Hr	s. 8. Date of Bir	th		
ı.	Director		578-12-3606	1□M 2\F 93	Yrs.	Months Days	Hours Min	May 10	,1911	Ital	lace (State or Foreign try) Y
	yland		Usual Residence of Decedent 10a. State 10b. County		, Town or Lo	cation				11	0d. Inside City Limits
	se Mar	Director	Maryland Prince	George's Cam	p Spri						1 □ Yes ※No
	with the or 2	Dire	10e. Street and Number 6610 Napoli Roa	ad		10f. Zip Code 20748			10g. Citizen o		try?
	death	Funerai	11. Marital Status	12. Was Decedent Ever in U	S. 13. \	Vas Decedent of His f Yes, specify Cubar		Specify Yes or No		ace - Americ	
36	filed within 72 hours after death with the Maryland Hygiene. ther then "neturel", or Items 23a or 28e-f show whit, the Medical Examinat must be motified at	by Fu	1 Never Married 2 Marrie 3 Widowed 4 Divorced	If Yes, Give	1	Tes 2XXNo	Specify:	into riloan, etc./		ack, White, e <i>ity:</i> Whit	
8	2 hour	ted b	15. Decedent's		16a. Deced	lent's Usual Occupa	tion		16b. Kind of		
215	vithin 7 ne. hen "n	Completed	(Specify only highest	College (1-4or 5+)		lent's Usual Occupa kind of work done d DO NOT use retired) Person	uring most of w	orking	D-+ :1	D	C.
7	filed v Hygie other t	Be Co	9th 17. Father's Name (First, Middle, L	ast)	Sales		18. Mother's Na	ame (First, Middle		-	. Stores
ylan	Mental Mental arked artic ev	To B	Pasquale Marti	no			Filome	na Pren	cipe		
Baltimore, Maryland 21215-0036	d 2 sho h and 7 is mu treum		19a. Informant's Name/Relationshi Barbara Stroup/I		3	g Address <i>(Street</i> a Henderson					
ē,	f Healt		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place		Date	20c. Location		
<u>E</u>	Page menf o ent: If ury or		1 Burial 2 □ Cremation : `4 □ Donation □ Other (Spi	Dremoval from State, Cad.		l Cemeter		8/05	Suitlan	d,MD.	
Balt	permif. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then "neturel", or Items 23a or 28e-f show any injury or other treumatic event, The Madical Examinating must be notified at once.		21. Signatur of neral Service L	Calso.		Name and Address					1 Home, P.A nd 20745
ļ,				omplications that gay sed the death nly one cause on sech line.					rrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a / / Cul	uence of):	eremal	11	terct	1)		-
	Examiner		Sequentially list conditions	b. Atria	1	brillati	01				
	ted sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulsatie or hypry	Due to (or as a consequ	uence of):					6	
oʻ	execu an and rial-tra	Exar	that initiated events resulting in death) Last	C. Due to (or as a consequ	uence of):						
8760,	cate be executed oblysician and the burial-transit	dicai		d							
9	death certific attending pl	/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. D	ate of delive	rv
.O. Box	that the death led by the atter detached for u	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown		Ectopic pregnancy Other (specify)					Day Year
s, D	P P P	by	Part II. Other significant condition	is contributing to death but not result to Cay Cino M. 9	ulting in the ur	iderlying cause give	n in Part I.		obacco use coi Yes 2 2 √o		e cause of death? ably 4 □Unknown
Record	law requir as been si 2 should	Completed	uphe	y Gashventest	tinal	bleed	۵,	24a. Was		. Were autop	osy findings available
m m	Physicien: The law r this certificate has t iral director, page 2 s		J V					perfo 1 ☐ Yes	rmed?	death? 1 🗆 Yes	
Vital	/sicien s certifi director	То Ве	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	FB/Outpatien	Othe		eath <i>(Check only o</i> Home 5 🗆 Resi		ther (Specify	()
Division of	ng Phy ter this neral c		27. Manner of Death	28a. Date of Injury	28b. Time of Injury	28c. Injury Work	at	28d. Describe			,
Siol	tendir seath. tor: Af the fu	catic	2 Accident investiga 3 Suicide 6 Could no	ation of he		M 1 □ Y	es 2 □ No	206 Lecation (C4		
DIX	after after Direct	Certification:	4 Homicide determin	28e. Place of Injury - At ho building, etc. (Specify	me, rann, sue	ен, гастогу, опісе		City or Tol		iber or nurar	Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	edical C	(Check only 2 Medical E	Physician: To the best of my know	wledge, death ion and/or inv	occurred at the time restigation, in my op	e, date and place inion, death occ	ce, and due to the curred at the time,	cause(s) and m	nanner as sta , and due to	ated. the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certain	and manner stated.		29c. License	number		29d. Date sign	ed (Month, L	Day, Year)
}	->-0			PAUL		DH2	3351	f	1/17/	05	
	4		30. Name and address of person w	no completed leause of death (Item	201 (reenhol	+ Rd	Sinto	4-19	> N	11) 20740
	Sta		31. Date filed (Month, Day, Year)		ture	6.4.	7	20100			7 0 0 10 10
	Registi	ar	411111111111111111111111111111111111111	COOL MERCEN	10. 14						

			1 - For State Registrar	State	of Marylar	nd / Depa	artment o	f Health	and M	lental Hy	giene	005	01319
	Physicia		Decedent's Name (First, Midd DOROTHY	fie, Last)	BLA	ζF				2. Date of Dea Month 01	Day	Year 2005	3. Time of Death 1:59 P M
	/Medic Examin		4a. Facility Name (If not institution	on, give street and n		·CLI	4b. City, Tov	m, or Location	n of Death	01		ounty of Death	
	LAGITIII	e1	MARINER HEALT				FO	REST H	IILL		Н	ARFORD	
	Funeral Director		5. Social Security Number 212-12-0975	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 89	V	If Under 1 Y		er 24 Hrs.	8. Date of Birt (Month, Day April 1	h v, Year)	9. Birth	place (State or Foreign Intry) and
	pur .	-	Usual Residence of Decedent 10a. State 10b. Count	· · · · · · · · · · · · · · · · · · ·	10c Cit	tv. Town or Lo	ocation						10d. Inside City Limits
	fanyla r sho	ō		•	100.01								1 ☐ Yes 2 🛣 No
	the N	rect	Maryland Harf	ora		Forest	10f. Zip Co	de			10g, Citize	n of What Cou	intry?
	3a or		109 Forest	Valley Dr	ive			21050)		U.S.		,
	death	nera	11. Marital Status	12. Was De	ecedent Ever in U	.S. 13.	Was Decedent			ecify Yes or No- Rican, etc.)		Race - Amer	
9	after or Ite	by Funeral Director	1 Never Married 2 Ma	rried 1 Tyes	2 ⊠ No		1 ☐ Yes 2 🔯			riicari, etc.)	1	Black, White	, etc.
000	ural',	d b	3 ₩ Widowed 4 Divorce	d Year or	Dates:							Wh	ite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show tha Madical Exana her must be notified at	Completed	(Specify only high	nt's Education est grade completed	d)	(Give	dent's Usual O kind of work d DO NOT use re	one durina m	ost of worki	ng	16b. Kind	of Business/li	ndustry
7	iene.	omp	Elementary/Secondary (0-12)	College	(1-4or 5+)		omemake				0	wn Hom	e
פָּ	e filec al Hyg otha vant,	Be C	17. Father's Name (First, Middle	, Last)				18. Mo	ther's Name	(First, Middle,			-
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or items 23a or 28a-f show any injury or other traumatic evant, the Medical Examination at ange.	To E	William Fred	erick Gre	gorius				Li1	lian Wo	od		
lan	2 sho and is mu		19a. Informant's Name/Relation		`					l Route Numbe			
€, 2	l and fealth im 27 her ti		William E. Bla	ke (Son			and the second second second			l Air,		and 21	
וסר	to the state of th		1 ⊠Burial 2 ☐ Cremation		II GIALE		natory or other		 				
Baltimore,	it. Partmer		' 4 □ Donation 5 □ Other (21. Signature of Funeral Service		Lou		rk Ceme						Maryland
Ba	Depa Impo any ir			- 1	11290	1.6	litzke	Funera	1 Home	e of Cat	tonsv:	ille,	Inc. land 21228
			23a. Part1. Enter the disease, shock, or heart failure. Lis	or complications that	t caused the deat							, mary	Approximate Interval Between
b	Pnysician		Immediate Cause (Final disease or condition	or only one cause of	oacii iiio.		cete						Onset and Death
	/Medical		resulting in death)	aDue t	o (or as a consec	quence of)					
П	Examiner	_	Sequentially list conditions,	b	,								
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹ Due t	o (or as a conseq	quence of):							
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c	o (or as a consec	quence of):							
8760,	ate be executed hysician and the burial-transit	icalE											
9	tificate g phy as the												
Вох	death certifica e attending ph id for use as ti	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		⊒Ectopic pregn	ancv			230	d. Date of deliv	,
-		sick	in the past 12 months?		gnant at time of c		Other (specif					Month	Day Year
0.0	iaw requires that the de as been signed by the a 2 should be detached f		9 ☐ Unknown Part II, Other significant condit	ions contributing to	death but not rec	rulting in the u	Indorhina anua	o grupo in Pa	rt I	23e Did to	phaceo use	contribute to	the cause of death?
ds,	signe d be c	d by	Co - o O - O	7	O	Sulling in the d	0-0	e giveriir a	11.1.			No 3 ☐ Pro	\
Records,	w require been si should I	Completed	_ comed	· · · · · · · · · · · · · · · · · · ·	un c				-	24a. Was a			
Rec	0 4 0	mp								autop perfor	sy med?	prior to co	opsy findings available ompletion of cause of
Vital	ician: Th certificate ector, pag	e Cc	25. Was case referred to medic	al				26 PI	ace of Death	1 Yes		1 🗌 Yes	<u>\$</u> Q №
į.	Physician: this certific ral director,	0 B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DOA			me 5 ☐ Resid		Other (Speci	fv)
J of		n; T	27. Manner of Death Natural 5 Pend	28a. Dat	e of Injury onth, Day Year)	28b. Time o	of 28c.	Injury at Work?		28d. Describe h			
Sio	Attending r death. actor: After oy the fune	atic	2 ☐ Accident inves	tigation			М	1 Yes 2	□No				
Division	or Atten after deat Diractor:	Certification;	3 ☐ Suicide 6 ☐ Coule 4 ☐ Homicide deter	mined 286. Pla	ce of Injury · At h Iding, etc. (Specia	ome, farm, st fy)	reet, factory, of	fice		28f. Location (S City or Tow		lumber or Rur	al Route Number,
2	pitat ours a aral C		29a. Certifier Certify	ing Physician: To t	he heat of my kny	awladgo dost	th oncurred at t	no timo, dato	and place	and due to the	20100(0) 00	d mannar as	risted
Be	To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by	edicai	(Check only 2 Medics	I Examiner: On the	basis of examina anner stated.	ation and/or in	ivestigation, in	my opinion, o	leath occurr	ed at the time, o	date and pla	ace, and due	to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certif	er			29c. Li	cense numbe	ər	- 4	29d. Date s	igned (Month,	Dey, Year)
)			Darl	50			T	32	275		JAZU	. Je 10	9 2000
			30. Name and address of perso		•								• ,
			DR. DAVID DU				D, BEL	AIR, I	MD 21	.014			
	Sta Registr		31. Date filed (Month, Day, Year SAN 2 1 206	15 2 32.	Registrar's Signa	ature	ð						
	7.091011	-11.6	2.00	15 Alestus	A State of	STATE OF THE STATE							

			For State Registrar	State	of Marylar		artment of H			jiene	05	01320
	Dharini		1. Decedent's Name (First, Middle, La	st)					2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		Frances G. Bi						1 /	4 20	505	11:45 AM
	Examin	er	4a. Facility Name (If not institution, giv	e street and no	imper)	20. Vel	4b. City, Town, or	Location of Death	1	4c. County		mico
	,		Teninsula /(egioni	VI 11104	ICM CO	WU	If Under 1 Year	If Under 24 Hrs.	0.00.4.48:41			
	Funeral Director		5. Social Security Number 6. S 220-14-0258	1 □ M 21区 F	7. Age (In yrs. 83	.,	Months Days	Hours Min.	8. Date of Birth (Month, Day Oct. 9,	Year) 1921	Mar	place (State or Foreign ntry) y land
			Usual Residence of Decedent		1		<u> </u>	l	0000, 7,	1721	1101	y rand
	nylan ihow	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
	Be-f s	Directo	Maryland Wicomi	.co		Salisb						1 ☐ Yes 2551No
	death with the Maryland ms 23e or 28e-f show I must be intiffed at	Dire	10e. Street and Number		_		10f. Zip Code		1	0g. Citizen of		ntry?
	sath v	eral	30607 Olde Fru			S 12	218		pacifu Vac or No.	U.S		can Indian,
	fter de ritem	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed F	edent Ever in U orces? 2점]No	.3.	Was Decedent of H If Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)	Bla	ck, White,	
	O36	by	3 Widowed 4 ☐ Divorced	If Yes, G Year or I	ive Dates:		1 ☐ Yes 2 No	Specify:		Specif	^{y:} Whi	ite
	5-0 72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occup	ation	rkina	16b. Kind of B	lusiness/In	ndustry
	Men in Man	lg m	Elementary/Secondary (0-12)		(1-4or 5+)		kind of work done of DO NOT use retired)		_		
	1 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		11. 17. Father's Name (First, Middle, Last	•)		Hou	sewife	18 Mother's Nan	ne (First, Middle,		Home	
	Maryland 21215-0036 nd 2 should be filed within 72 hours after lith and Mentat Hygione. 27 Is marked other than "natural", or Ite rtraumatic event, It's Modical Examina	o Be	Herman Burke	,					Le Ruhl	valuen oamar	110)	
	Shout Me Me mark	2	19a. Informant's Name/Relationship	Type, Print)		19b. Maili	ng Address (Street a			r, City or Town,	State, Zip	o Code)
	Md 2 alth a alth a 27 is		Horace Biederman	n (Sor	1)	30607	Olde Fru	itland R	Rd. Salis	bury, 1	Mary1	and 21804
	altimore, M mit. Pages 1 and 2 partment of Health is portent: If item 27 1 y injury or other tra 28.		20a. Method of Disposition	70	20b. F		sition (Name of matory or other place			20c. Location		
	Pages nent of lent of lent or		1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Speci		Jale		Memorial	1	9-2005	Sykesvi	11e,	Maryland
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygione. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event. If a Modical Examinal must be inclifted at once.		21. Signature of Euneral Service Lice	Ta .	lot	W:	Name and Address itzke Fun 30 Edmond	ss of Facility eral Hom- lson Ave.	e of Cato	onsvill	e, In	nc. and 21228
	- P		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that	caused the deat						141	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	P		onia						Onset and Death
Do	/Medical Examiner		resulting in death)	Due to		uence of):	1	. [1
250-	LAMINICI	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Due to	(or s a conseq	Jostes	(op	the)				26 WKs
7	ted	nine	Cause (Disease or injury	m	. A se se de	L						Struke
p11-08	760, be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):						16 Wices
22	8760, cate be exphysician the burial			o	OPD							
	difficantificant	Medi	IF FEMALE:									
n	Box 68 eath certific attending p	an/I	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregna birth 2 - Feta	al death 3	Ectopic pregnancy				ite of delive	ery Day Year
edermann	ords, P.O. Box 68760, requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	Physician/Medical	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∏Preg 9□ Unki	nant at time of d nown	leath 5	Other (specify)			IVIC	2101	Day Tou.
7	cords, P.O. I		Part II. Other significant conditions	contributing to	death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did tol	pacco use con	tribute to ti	he cause of death?
Le	ecords, law requires t as been signe 2 should be	Completed by	AFib						1 🗆 Ye	es 2□No	3 🗆 Prot	pably 4 Dunknown
6	() > 0 0	olete	HOH						24a. Was a	n 24b.	Were auto	psy findings available mpletion of cause of
13	age h	mo	Nement to	-					autops perform	ned?	prior to co death? 1 🗌 Yes	
١٨	(0 ==	Bec	25. Was case referred to medical examiner?	e	1			26. Place of Dea	th (Check only on			
0	of Vital Physicien: 1 rithis certifical ral director, p	To	1 No 2 No	Hospital: 1 2		ER/Outpatier	nt 3 DOA Othe	er: 4 🗆 Nursing H	ome 5 Reside			(y)
rances	on of Jing Phys	lon:	27. Manner of Death 1		of Injury onth, Day Year)	28b. Time o Injury	Worl		28d. Describe ho	ow injury occur	red	
12	Division or Attending after death. Director: After	Icat	2 Accident investigation 3 Suicide 6 Could not be		e of Injury - At h	ome, farm, str		Yes 2 □ No	28f. Location (St	reet and Numb	er or Rura	al Route Number
A	Div A after after I Direct	Certification:	4 Homicide determined	build	ting, etc. (Specif	(y)	reet, factory, office		City or Town	n, State)		
	Division of Vita Vita Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying P	hysicien: To th	e best of my kno	owledge, deat	h occurred at the tim	ne, date and place	, and due to the ca	ause(s) and ma	anner as s	tated.
	the H nin 24 the Fi	Medical	one)		nner stated.	ation and/or in						
	To with	1	29b. Signature and title of certifier	۸	\circ		29c. License			9d. Date signe	d (Month,	Day, Year)
			() len	and a	L.	n 220) (T		06/3	<i>x'</i> /	1/14	105	
	11/11		30. Name and address of person who Elleda Ziemer,				et Salis	sburv. MT	21804			
	Sta	ite	31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ature						
	Registr	ar	JAN 2 1	2005	Men .	J.S.	grave					

			For State	-	partment of Health and M	ental Hygie	ene 2005	01331		
			Registrar AMEND IT	EM #31 PER DVR G839	Reg 2. Date of Death	. No.	3. Time of Death			
	Physici		CATHERINES	O BARNES		Month O (Day Year	1052 M		
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)	4b. City, Town, or Location of Death		4c. County of Death	1.73		
			NORTH AKUNDEL	4089 - E.R.	GLEN DRME MO		A.A.			
	Funeral Director		5. Social Security Number 2.1 9-50-2750 Usual Residence of Decedent	Sex 7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthp Gound 1946 Nor	lace (State or Foreign TA Canlina		
	within 72 hours after death with the Maryland ene. than "neturel", or items 23a or 28e-1 show the Medical Examinat must be notified at		10a. State 10b. County	10c. City, Town or I	Location		1	0d. Inside City Limits		
		ctor	MD AA.	GLEN B	OURME MO			1 es 2 No		
		Funeral Director	10e. Street and Number 7805 Brutor	Drive Apt. H	10f. Zip Code 21060	10g	. Citizen of What Cour	ntry?		
5-0036	urs after dea el', or Items Examinatina	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced		I. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban Mexican, Puerto F 1 Tyes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Bla			
21215-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "neturel", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinar must be maillised at DDCs.	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	grade completed) (Giv	redent's Usual Occupation re kind of work done during most of working DO NOT use retired)	ng	State of	41 1 4		
Maryland 2		To Be C	17. Father's Name (First, Middle, La		18. Mother's Name Pauline	(First, Middle, Ma Taylo	iden Sumame)			
			0-1,09-11	-daughter 60	7 109	Lare I	Baltimore,	Maryland		
Baltimore	. Pages 1 tment of Hi tant: If iter jury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 '4 ☐ Donation 5 ☐ Other (Spe	city) Arbutt	omatory or other place) I Mem. Fark 1/2	2-105 P	c. Location - City or To	Mayland		
Ball	permit. Pag Department Important: I eny injury c		21. Signature of Fune all ervice Lic	farker	22. Name and Address of Facility 3512 Frederick	Ave. B	nal Sorvatinore	MD 21229		
	The law requires that the death certificate be executed EX A place is a possible of the attending physician and a place is a should be detached for use as the burial-transit		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ———————————————————————————————————							
		Ĺ	Sequentially list conditions.	Due to (or as a consequence of): PULMURAFU EMBUSM Due to (or as a consequence of):						
		Completed by Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	COMGESTIVE	HEART FAILURE					
,092			resulting in death) Last	Due to (or as a consequence of): d. IMSULIN DEFE	ELEDERET DIABETE	es mel	111705			
P.O. Box 68			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		☐ Ectopic pregnancy		23d. Date of deliver	ery Day Year		
Records, P			_	s contributing to death but not resulting in the		cco use contribute to the	ne cause of death? ably 4 □Unknown			
CO			coreviAfer F	Herefy MSEAS E		24a. Was an	24b. Were auto	psy findings available inpletion of cause of		
R			CHIROTHIC C	BUTTE CTIVE PUL	MOHARY DISEAS	autopsy performe	d? death?	2 No		
Vital	yslcien: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?		26. Place of Death					
of \	Physicien: rthis certificaral director,	မ	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati				()		
onc	Attending It death. Color: After Attheby the fune	tlon:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury 28b. Time (Month, Day Year) Injury		28d. Describe how	injury occurred			
Division		Certification;	3 Suicide 6 Could no determine	t be an Bloom of Injury. At home form		28f. Location (Stree City or Town, S	et and Number or Rura State)	l Route Number,		
	ne Hospitel or n 24 hours afte ne Funerel Dir pletely filled in	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my knowledge, de. (aminer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the caused at the time, date	se(s) and manner as st and place, and due to	ated. the cause(s)		
	To the within 2 To the complet	M	29b. Signature and title of certifier	Van	29c. License number	29d	Date signed (Month,	Day, Year)		
	0		De magne	no completed source of death (the control	11 24 T4 8		110103	150		
_	9		290. Signature and title of certifier N. Mayura D29748 1/18/0-5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLIF MANETWALA, M.D. 1307 CHAIN FELLY GLENBURYE MD21061							
	Sta Regist		31. Date filed (Month, Day, Year)	N 2 1 2015 Signature	S. Speche					

RPD	00378		UNpend literate 1. State	Type or Print in I 23a, 27, 28a-f, State of Marylar					II Copie Iental H	s Are	Legible e200	5 0132	
			Registrar 1. Decedent's Name (First, Middle, La	ast)	Ce	ertificate o	t Death	7	2. Date of D	Reg. No	o	3. Time of Death	
	Physici /Medi			MOND BROWN, II	Ι				Januar	y 16	2005	ir .	
	Examir		4a. Facility Name (If not institution, given 220 North Gay St.	re street and number)		4b. City, Town Baltimo		of Death			c. County of De	eath	
1961	Funeral Director		5. Social Security Number 212-82-3426 Usual Residence of Decedent 6. Sex 1			y) If Under 1 Yea Months Day		If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 02-09-19					
4	e Maryland a-f ehow	ctor	MD 10b. County N/A		ity, Town or							10d. Inside City Limits X□ Yes 2 □ No	
	with th	Dire	10e. Street and Number			10f. Zip Code				10g. C	itizen of What	Country?	
	eeth v	Funeral Director	1605 SPRAY CT.	12. Was Decedent Ever in U	LS 13	212 Was Decedent o		rigin? (Sp	ecity Yes or N	NO-	US 14. Bace - A	A merican Indian,	
5-0036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Exprises in the Exercities at	by	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ No 1 □ Yes 3 □ Yes 1 □ Yes 4 □ Yes 1 □ Yes 4 □ Yes 1 □ Yes 5 □ Yes 1			 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify: 				Black, White, etc. Specify:BLACK			
21215-0		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						16b. h	6b. Kind of Business/Industry			
d 2	filed w Hygie ther t		17. Father's Name (First, Middle, Las.	1	NUR	SING TECH			e (First, Midd	le, Maidei	HEALT	H	
an	ild ba fental rked o fic eve	To Be	WILLIAM RAYMOND B						TURNEF		,		
N S	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marke any injury or other traumatic. ODGE.		19a. Informant's Name/Relationship GLORIA BROWN/STEP	• • • • • • • • • • • • • • • • • • • •	19b. Ma	iling Address (Stre 1605 SPF							
Baltimore,			20a. Method of Disposition ⇒ Burial 2 ☐ Cremation 3 ['4 ☐ Donation 5 ☐ Other (Special Content of the Conten	□Removal from State G	Place of Dis cometery, cr ARRIS(position (Name of lematory or other p ON FOREST	VET.	1/28	Date 3/05		ocation - City	or Town, State LS, MD	
Balt			21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., I 1701 LAURENS ST., BALTO., MD 21217									ONS F.H., IN	
	Physician /Medical Examiner	iner	23a. Partř. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (usease or myury	a. Alcohol In Due to (or as a consect Due to (or as a consect Due to (or as a consect Due to (or as a consect)	ntoxic quence of):		ying, such as	s cardiac d	or respiratory	arrest,		Approximate Interval Between Onset and Death	
x 68760,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely tilled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec									
P.O. Box		Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	in the past 12 months? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No							23d. Date of o	delivery Day Year	
		Completed by Pt	Part II. Other significant conditions	contributing to death but not res	sulting in the	underlying cause	given in Part	l.		tobacco		to the cause of death? Probably 4 Unknown	
of Vital Records,									24a. Wa aut per Y Yes	opsy	prior t death	autopsy findings available o completion of cause of ? es 2 □ No	
n of Vita		n: To Be	25. Was case referred to medical examiner? 1X1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpati 28b. Time Fnct jury	of 28c In	Other: 4□N	lursing Ho	n <i>(Check only</i> me 5 ☐ Rea 28d. Describe	sidence		pecify) At Scene	
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director; Attencompletely filled in by the fune	Certification:	2 Accident 3 Suicide 4 Homicide 1/15/05 1 1:55 p 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							unk. 28f. Location (Street and Number or Bural Boute Number, City or Town, State) 220 N. Gay Street			
	To the Hospitel or Attent within 24 hours after death To the Funerel Director; completely filled in by the	edicai Co	29a. Certifier (Check only one) 1 Certifying P	Shelter hysician: To the best of my kniminer: On the basis of examination and manner stated.	owledge, dea ation and/or	ath occurred at the investigation, in my	time, date a opinion, de	nd place,	altimo and due to the ed at the time	e cause(s	and manner	as stated. ue to the cause(s)	
	To th withir To th compl	Me	29b. Signature and title of certifier	hall- 00	Ma	29c. Lice	nse number				ite signed <i>(Mo</i> 1ary 16	nth, Day, Year)	
14	10K	The state of the s	30. Name and address of person who	completed cause of death (Item	l11 Pe	nn Street		timon	re, Mai				
	Sta Regist		31. Date filed (Month, Day, Year) JAN 2 1	32. Redistrar's Sign:	ature	Sperte							

			Please Type or Prin		k indelible ink Department of I					
			1 - For State Registrar	-	Certificate of		Reg. N	- 21105	0132	
	Physici /Medic	cal .	1. Decedent's Name (First, Middle, Last)	nee	Buff	ington	2. Date of Death Month D	av Year	3. Time of Death	
	Examin		4a. Fecility Name (If not institution, give street and number) St. Tizabeth Navsi'M	a Cent		or Location of Death	ove	tc. County of Death		
100	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birt	thday) If Under 1 Year		8. Date of Birth (Month, Day, Yea	N/A 9. Birthplac	ce (State or Foreign	
	Director		214-03-3024 XXM 2□F	97	Yrs. Months Days	Hours Min,		907 Mary		
	land iow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	n or Location		····	10d.	. Inside City Limits	
	8a-1 st	Director	Maryland N/A		Baltimore				tXTXYes 2 □ No	
	should be jiso within 1.2 hours after death with the Marylat not defined i Hygiene. The Marylater sharp "natural", or items 23a or 28a-1 show marked other than "natural", or items 23a or 28a-1 show marke other than "natural Examinatio event, the Marylatel Examination and the marylater in the ma	Dire	10e. Street and Number St. Elizabeth's 3320 Benson Avenue	Nursing	Ctr 10f. Zip Code 21	227	10g. (Citizen of What Country USA	?	
	death	Funeral	11. Marital Status 12. Was Decedent E	ver in U.S.	13. Was Decedent of I		cify Yes or No-	14. Race - American		
36	72 hours after death with the Maryland natural; or Items 23e or 28e-1 show acel Examiner must bu maillined at	by Fu	1 ☐ Never Married 2 ☐ Married 1 X X 9s 2 ☐ N		1 ☐ Yes 2 X No		indin, etc.)	Black, White, etc	nite	
Maryland 21215-0036	2 hour	Completed b	15. Decedent's Education		Decedent's Usual Occup	pation	16b.	Kind of Business/Indus		
21	⊆ - 3		(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	+)	(Give kind of work done life. DO NOT use retire					
22	should be filed within nd Mental Hygiene	e Co	10th 17. Father's Name (First, Middle, Last)		Insurance S	T	(First, Middle, Maide	udential Ir en Sumame)	nsurance	
lan	uld be Aental rked c	To Be	Lawrence C. Buffington			Katie				
lar,	2 sho and P Is ma rauma		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street				ode)	
	1 and 3 Health tem 27		Lenora M. McKenzie Niece 20a. Method of Disposition		35 Carmella Disposition (Name of y, crematory or other pla			MD 21227 Location - City or Town	, State	
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 Is marke any injury or other traumatic once.		XXSurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		y, crematory or other pla and Veteran		1/26 Ga:	rrison Fore	est. MD	
Salti	permit. Page Department of Importent: If any injury or once.		21. Signal Funeral Service Lipenspe			ess of Facility nss-Seitz s Road Ba			,	
	0.0 2 6 0		23a Part 1. Enter the disease, or complications that caused	the death. Do r	3631 Falls	s Road Ba	ltimore,	Ar	211 pproximate	
# S	hysician		shock, or heart tailure. List only one cause on each line immediate Cause (Final	9.	nentia		Toopington, arrow,	Int	terval Between nset and Death	
	/Medical Examiner		disease or condition resulting in death) Due to (or as a	consequence	of):	1		- Y	I YUVS	
M	Examiner	<u></u>	Sequentially list conditions, I b. Due to (or as a consequence of): Due to (or as a consequence of):							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.							
,60,	te be executed ysician and e burial-transit	al Ex		consequence o	of):					
289	ficate t physical ts the b		d							
Вох	The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth		3 □Ectopic pregnanc	v		23d. Date of delivery		
о п	he dea the att	ysici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		5 Other (specify)	7		Month Da	y Year	
	res that the de signed by the s be detached	by Ph	Part II. Other significant conditions contributing to death bu	t not resulting in	the underlying cause giv	ven in Part I.	23e. Did tobacco	use contribute to the c	cause of death?	
ords	w require been sig should be	ted b	Hypertension					Yes 2 No 3 Probably 4 Unknown		
Vital Records,	a law n has be e 2 sh	Completed					24a. Was an autopsy	24b. Were autopsy prior to comple	findings available letion of cause of	
		e Co	25. Was case referred to medical				performed?		□ No	
<u> </u>	nysicia nis cert direct	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatier	t 2 ER/Out	tpatient 3 DOA Oth	26. Place of Death ner: 4 Nursing Hom		6 ☐Other (Specify)		
DIVISION OF	ding Pt h. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day		njury Wo	ry at 20	3d. Describe how inj			
VISIC	Attend death octor: y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injur	ry - At home, far	M 1 rm, street, factory, office	Yes 2 No	Bf. Location (Street a	and Number or Rural Ro	oute Number,	
<u> </u>	tal or rs afte el Dire ed in b	Certification:	4 Homicide determined building, etc.	(Specify)			City or Town, Sta	te)		
	To the Hospital or Attending Physician: inin 24 hours after death To the Funerel Director: After this certifica completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state	examination and	, death occurred at the til d/or investigation, in my d	me, date and place, ar opinion, death occurre	nd due to the cause(d at the time, date a	s) and manner as state nd place, and due to the	e cause(s)	
	To the within ? To the comple	Med	29b. Signature and title of certifier	1	29c. Licens	se number	29d. D	ate signed (Month, Day	y, Year)	
	X		· my	mo	0.	55391	Jar	mary 19.	, 2005	
1	7		30. Name and address of person who completed care of de	1	Type, Print)	Saltim	77.7	1	21777	
2	Sta	te	31. Date filed (Month, Day, Year) 32. Begistral		enne. 1	JUG I IVI	101	aryland	61661	
	Registr		JAN 2 1 2005 Seren	· K	Speeks					
DHM	IH 17 Rev 1/20	001	JP		GINAL					

05-00424 B.K.S unpend item#23a, 27, 28a-f, perME, G839, 1/31/05 TT State of Maryland / Department of Health and Mental Hygiene OTIS BROOKS JR. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2005^{Year} **Physician** JAN. 18, Brooks Jr. 0851 A /Medical 4a. Fecility Name (If not institution, give street and number) 6614 O DONNELL STREET 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE CITY If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 🖳 M 2 🗆 F Director 216-76-8534 August 1,1959 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumetic event, the Madical Exeminer must be notified at 1 ☑ Yes 2 ☐ No Director Maryland NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6614 O'Donnell Street 21224 U.S.A. or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. □Yes 2□No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1□Yes 2□No Specify: Specify: White ģ 3 Widowed 4 Divorced Year or Dates: neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed w th and Mental Hygier 7 is marked other th Grave Digger 8 NA Cemtery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Brooks 0tis Sr. Dorothy Crouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is rr eny injury or other treurr once. 3117 Yorkway Baltimore, Maryland 21222 Donald Brittingham 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 1 Burial 2 □ Cremation 3 □ Removal from State Sacred Heart of Jesus 22,2005 4 □ Donation 5 □ Other (Specify) Dundalk, Maryland 22. Name and Address of Facility, W. Dabrowski/Chojnacki Funeral Homes P.A. 21. Signature of Funeral Service Licensee 1005 Dundalk Ave. Baltimore, Md. 23a. Peril 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Heroin Intoxication And Cocaine Use Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Complicated By Hypothermia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): attending physician Box 68760 certificate be Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1**X** Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Nother (Specify) AT SCENE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 XYes 2 ☐ No ပ 3□ DOA 27. Manner of Death 28a. Date of Injury Fnd onth, Day Year) Pnd jury 28d. Describe how injury occurred al or Attending P after death. I Director: After Certification: Injury at Work? 1 Natural 5 Pending 2 Accident investigation 1/18/05 8:35 A unk 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6614 0 Donnell St Baltimore, MD 4 🗌 Homicide Scene 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E 19, 2005 JAN. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET, BALTIMORE, MARYLAND 21201

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JAN 2 1 2005

. Registrar's Signature

5-00341 Cerry Burton, Jr.

Pleasa Type of Print in Black Indelible Ink, Ensure All Copies Are Legible.

			1- State amend item #11 pe	State of M r wife G85	laryland / Do 4 4/20/06 a	epar Cert	tment of	Healtl of Deal	i and N	Mental Hy	giene Reg. No	2005	01325	
			1. Decedent's Name (First, Middle, Last)							2. Date of D	eath		3. Time of Death	
	Physici /Medic		Terry Lee	Burton,	Jr.					Januar	cy 14	2005	12:55 №	
>	Examin		4a. Facility Name (If not institution, give				4b. City, Tow				4c.	. County of Death		
			530 North Carrollt					ltimo		T		N/A		
Š	Funeral Director		212-90-4362	XM 2□ F	ge (In yrs. last birth 29 Yı	//	If Under 1 Ye Months Da		der 24 Hrs. s Min.	8. Date of 8 (Month, D Dec • 2	3, 1	9. Birthplace (State or Foreign Country) 1975 Maryland		
) .	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loca	ation						10d. Inside City Limits	
	Many 1 sh	to	MD Balt	imore			Balt	imore					1 ☐ Yes 2 No	
	r 28a	irec	10e. Street and Number	Zino z o			10f. Zip Cod				10g. Cit	izen of What Cou	intry?	
	23a o	a D	4103 Oak Road					2122	7		U:	nited St	ates	
21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural, or items 23a or 28a-f show or other traumatic event, the Medical Exarting Frust be inclined at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☑ Weisesd	12. Was Decedent Armed Forces 1 Yes 20 If Yes, Give Year or Dates:	? No		as Decedent of Yes, specify C			ecify Yes or N Rican, etc.)	0-	14. Race - Ameri 8lack, White Specify: WH		
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad		16a. C	Decede Give ki	nt's Usual Oc	cupation	ost of work	rina	16b. K	ind of Business/Ir	ndustry	
121	Aithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		nd of work do O NOT use re			9	D	rinting		
2	Hygie ther t		17. Father's Name (First, Middle, Last)			P	ressma		ther's Nam	e (First, Middle				
and	d be f	o Be		C۳						ay Mill		Sumanie		
Maryland	d 2 should be filed within ? h and Mental Hygiene. 7 is marked other than "! traumatic event, the Med	2	Terry Lee Burton, 19a. Informant's Name/Relationship (Ty		19b. N	Mailing	Address (Str			,		or Town, State, Zi	p Code)	
S	nd 2 aith a 27 is r trau		Terry Burton Sr.	Father						nore, M			ŕ	
ŗe,	s 1 a of Hea item othe		20a. Method of Disposition		20b. Place of D	Disposit	tion (Name of		_	Date		ocation - City or T	own, State	
Ē	Page nent c		8urial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Glen Ha Memoria	Υep	ark	,	1-20	-2005	G1	en Burni	e, MD	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trae		21. Signature of Functial Service Licens	NO.	TOX	22.	Name and Ad					1 Home, tus, MD		
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that cause	d the death. Do no	t enter	the mode of	dying, such	as cardiac	or respiratory	arrest,		Approximate Interval Between	
	Prrysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as	C Arrhythi s a consequence of):							Onset and Death	
	ted nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disass or injury) that initiated events	Due to (or as	s a consequence of):								
8760,	cate be executed physician and the burial-transit	dicai Examlner	that initiated events resulting in death) Last	Due to (or as	s a consequence of):								
9	ntifica ng ph	a a	IF FEMALE:									-		
P.O. Box	The law requires that the death certific ite has been signed by the attending rates as sage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		e of pregnancy 2 Petal death at time of death		ctopic pregna Other (specify					23d. Date of deliv Month	rery Day Year	
	es that igned b be deta	by PI	Part II. Other significant conditions con	ntributing to death	but not resulting in t	he und	erlying cause	given in Pa	rt I.	23e. Did	tobacco ι	use contribute to t	the cause of death?	
rds	v require been sig should b	ed t								1 🗆	Yes 2	□No 3□Proi	bably 4 Unknown	
I Records,	l cian: The law requ certificate has been ector, page 2 shouk	Completed								24a. Wa auto peri NO Yes		prior to co death?	opsy findings available ompletion of cause of	
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	fospital:						h (Check only		1717	COUNT	
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u	ding F h. After funera	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	ay Year) 200. Inju		\ \	njury at Vork? Yes 2	□No	28d. Describe	now injur	y occurred		
Division	al or Attending s after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	njury - At home, farm etc. <i>(Specify)</i>	n, stree					(Street an own, State	d Number or Run)	al Route Number,	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edicai	29a. Certifier Cartifying Physics (Check only one) Madical Exami		t of my knowledge, of examination and/otated.									
`	With To 1	Σ	29b. Signature and title of certifier But F. Mat					O.C.M				te signed (Month, lary 15,		
			30. Name and address of person who co	47	111	. Pe	enn Str	eet,	Balti	more, N	Maryl	and 2120)1	
ā	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 1 2005	32. Regist	trar's Signature	Self.	0							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** January 19,2005 Constance K. Cornelius 8:39PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Westminster Nursing Home Westminster Carrol1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1□M XXXF Director 183-34-7639 52 Oct.24,1952 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show f Health end Mentel Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at Y∑Yes 2 □ No Funeral Director MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1234 Washington Rd. 21157 U.S.A. Peges 1 end 2 should be filed within 72 hours efter death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes XXNo If Yes, Give XIX Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes XX No Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Depertment of Health important: if item 27 Steven Bumgardner/ Friend 1234 Washington Rd. Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State 4 ☐ Donation 5 fil Other (Specify) Metro Crematory Inc. 1/20/05 Baltimore, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Fun ral Service License. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner the Hospital or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) end Division of Vital Records, P.O. Box 68760, physician Physician/Medicai Due to (or as a consequence of): for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 No ò 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed this certificate hes 2 No 1 🗆 Yes 1 ☐ Yes 2 No Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: s efter deau.

ai Director: After this c ၉ 1 Yes 2 No 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours ef To the Funeral DI completely filled in 29a. Certifier 1 🖳 🦠 rilfying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of chrtifier 29c. License number 29d. Date şigned (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) W. Middleton 688 Poole Road, Westminster, MD MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2005

			1 - For State Registrar	State of Mai	ryland		artmeni rtificate						005	01327
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1	LAGITII	lei	Laurel Regional 1					aure		OI Deatii				eorges
	Funeral		Social Security Number 6. Se	7. Age	(In yrs. las	t birthday)	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth			
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Baltimore,	Pages nent of ant: If i		20a. Method of Disposition 1 Burial 2 Cremation 3 To Section 4 Donation 5 Other (Specify)		Sylva Ceme	^{өtөгу, сгеп} an He	sition (Nam natory or oth Lights	e of her place)	Jan. 200	19,		ntown,	
Balt	permit. Departrimports any nji		21. Signatur of Pineral Service Licens	•		22	Name and Charl 1501	es I	, St	even	s Funera e. Balti	1 Ho more	me Inc	230
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	cations that caused the cause on each line. Respir		Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory arre	st,		Approximate Interval Between Onset and Death
Ť.	/Medical Examiner		resulting in death)	Due to (or as a c										1
		ь	Sequentially list conditions, if any, leading to immediate	Due to (or as a c			n Can	cer						1 year
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9	ding p	/Mec	IF FEMALE:	20 If you not come of										
Вох	death certificate be executed e attending physician and id for use as the burial-transii	Physician/Me	in the past 12 months?	3c. If yes, outcome of 1□Live birth 2 [4□Pregnant at tim	Fetal de	ath 3	Ectopic pre					23d	. Date of deli Month	very Day Year
o.	the y th	hysi	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9□ Unknown	70 01 002,1		011101 (300	(Ji)						
Records, P	sign sign d be	by	Part II. Other significent conditions cor	tributing to death but r	not resultin	g in the un	derlying car	use giver	n in Part I.			cco use		the cause of death?
ooa	e law requ has been je 2 shouli	Completed									24a. Was an	2	4b. Were aut	topsy findings available
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Vital	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					-		of Death	(Check only one			
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Ö	safter safter al Dira ed in by	Certification:	4 D Homicide	building, etc. (Specify)						City or Town,	State)		
	To the Hospital or Attan within 24 hours after deat To the Funaral Diractor: completely filled in by the	Medical	29a. Certifier (Check only one) 12 Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one) 12 Certifier (Check one) 12 Certifier (ician: To the best of ner: On the basis of ex and manner stated	amination	dge, death and/or inve	occurred at estigation, in	the time	, date and nion, deat	d place, a	nd due to the cau d at the time, dat	se(s) and e and pla	d manner as ce, and due	stated. to the cause(s)
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,	716	/	Mailia	XLCC	Col	11_)	กวว1	70			an.	L5,200	5
1	L		30. Name and address of person who co					a -						
	Sta	te	Marcia L. Will 75 31. Date filed (Month, Dey, Year)	T					n Bei	Lt MI	20751			
	Registr		JAN 2 1 20	32. Redistrar's	1 13	A.	rede	•						

			For State	State of Maryland / Dep	artment of Health and I		- V V U U Z O
	0		Registrar 1. Decedent's Name (First, Middle, Las		Tillicate of Death	Reg. N 2. Date of Death	3. Time of Death
	Physici /Medic		MABEL	P. CURRENS		JAN. B	2005 7.50A M
	Examir		4a. Facility Name (If not institution, give	2 1	4b. City, Town, or Location of Deat	h 4	c. County of Death
	Funeral		5. Social Security Number 6. Se		If Under 1 Year If Under 24 Hrs.	8. Date of Birth	BACTIMORE 9. Birthplace (State or Foreign
	Director		215 10 1051	☐M 2 F 3 Yrs.	Months Days Hours Min.	(Month, Day, Yea	AL MARYLAND
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
	e Man Sa-1 sh Hiffed	Director	MD Carro	II Wa	od bine		1 Tyes 2 No
	with the	Dire	10e. Street and Number	hina Ral	10f. Zip Code	10g. C	Citizen of What Country?
	death	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race · American Indian,
36	s after , or ite		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🗗 No	1 ☐ Yes 2 No Specify:	o nican, etc.)	Black, White, etc. Specify: (1) / Le
5-0036	72 hours after death with the Maryland Insturel', or Items 23e or 28e-1 show dreal Examiner must be notified at	Completed by	15. Decedent's Ed	ucation 16a. Dece	edent's Usual Occupation	16b.	Kind of Business/Industry
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ylan	2 should be and Mental Is marked o	To Be	Benjamin 1	+ Pindell	Vera	Hendrig	ues
Maryland			19a. Informant Jame/Relationship (7	1	ing Address (Street and Number or Ru	Las III	or Town, State, Zip Code)
	es 1 and of Health fitem 27		20a. Method of Disposition	ries - aaug 5130	o COCO DILLEG. osition (Name of ornatory or other place)	Date 20c.	Location - City or Town, State
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Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Light	2. 1 8		ALTI MORE	mo 21234.
			23a. Part1. Enter the disease, or comp	fications that caused the death. Do not en	Iter the mode of dying, such as cardiar	Or respiratory arrest,	X) HALFORY OF P.D. Approximate
N.	Fnysician		Immediate Cause (Final disease or condition	SEASON S			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
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Vital Records,	The law cate has page 2.	Completed	CONGESTION OF THE PROPERTY OF	JE NEHICT PA	hille	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
ital		Be C	25. Was case referred to medical examiner?	CILIS DE GIO	26. Place of Dea	1 ☐ Yes 2 ☐ N ath (Check only one)	6 1 □ Yes 2 □ No
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Division	if or Attendi after death. Director: A d in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, sti building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
Ω	spitel cours af		29a. Certifier 1—Sertifying Phy	sicien: To the best of my knowledge, deat	th accurred at the time, date and place	and due to the gauge	a) and manage as attend
	To the Hospitel of within 24 hours aft To the Funerel D completely filled in	Medical	(Check only 2 Medicel Exam	iner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occu	rred at the time, date ar	nd place, and due to the cause(s)
	withi Com	Σ	29b. Signature and title of certifier		29c. License number		ate signed (Month, Dey, Year)
	di		30. Name and address of person who c	ompleted cause of death (Item 23a) (Type,	Print)		1-18-05
_			WARTER	HEANER MO	5905 Cetu,	RCH LA	1-18-05 Hypes 21082
÷;	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 1	32. Registar's Signature	porte		

State of Mar	yland / De	epartment	of He	alth and	Mental	Hygiene

AKG		1- State of Maryland		artment ertificate			nd Mei	ntal Hy	•			
Physicia	an	Decedent's Name (First, Middle, Last)		rimoato	0, 0	Call		Date of De Month anuar	D	005 2005°	3. time	of Death
/Medic Examin		SHAWN O. CHAMBERS 4a. Facility Name (If not institution, give street and number) Malcolm Grow Hospital		4b. City, To		ocation of I		andar	4c.	County of De		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia:	st birthday Yrs.) If Under 1	-	If Under 24	Hrs. 8. Min. 9	Date of Bi (Month, Di - 25	rth av. Year)	9. 8	Birthplace (State Country) hington	or Foreign
Ind 21215-0036 be filed within 72 hours after death with the Maryland lat Hygiene. d other then "natural", or itema 23a or 28e-f show event, the Medical Examinat must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Md Prince George's 10e. Street and Number 4813 Homer Ave., 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 1 2 2 2 No. If Yes, Give Year or Dates: (Specify only highest grade completed) Elementary/Secondary (0·12) 12th 17. Father's Name (First, Middle, Last) Marvin C. Chambers 19a. Informant's Name/Relationship (Type, Print) Kim Blowe/ God Mother 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Town or L 13. 16a. Dece (Give life). 19b. Mailt 4813 ce of Dispendency, creed ar I	Was Decede If Yes, specific I Yes 25 Departs Usual of work DO NOT use Ing Address (3 HOmer Dosition (Name matory or oth Hill Ce 2. Name and 25 Mar	2(Int of Hist Y Cuban, Y Cuban, Y No Occupati done du retired) Ave of er place) Address y lar	Specify: In the specific state of the speci	? (Specify verto Richard Por Rural Report Rural R	irst, Middle erkin oute Numbout of Numbout o	10g. Citiz Un: 16b. Kir Cor Maiden : S er, City or Md 2 20c. Loc SCapit ash.,	ited S 14. Race - An Black, WI Specify: B nd of Busines 1. Struc Sumame) 7. Town, State 20746 cation - City of uitlan col Mos	10d. Inside 0 tx Yes Country? tates nerican Indian, hite, etc. lack ss/Industry tion c. Zip Code) or Town, State d, Md. rtuary 20002 Approximal Interval Be	City Limits s 2 □ No
Physician Medical Examiner Medical Examiner Physician and Physician and Physician are the prival-transit Physician are the prival-transit Physician are the prival-transit Physician are the physi	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any learn to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a consequence consequen	nce ofj:	shot	wo	2W00	(5				Onset and	Death
P.O. Box 68 nat the death certifice of by the attending present of the stending present of the set	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	eath 3	⊒Ectopic preg]Other (spec					25	3d. Date of d	,	Year
Cords, P.O.	þ	Part II. Other significant conditions contributing to death but not resulting	ng in the u	inderlying cau	se given	in Part I.		23e. Did t		1	to the cause of o	death? Unknown
Vital Reco	e Completed	25. Was case referred to medical						1 Yes	osy ormed? 2 \(\text{No}	24b. Were a prior to death?	autopsy findings completion of costs	available ause of
on of ding Phys	Certification: To B	examiner? 1XXves 2 ☐ No Hospital: 1 ☐ Inpatient 2 🗵 EF	8b. Time (Injury	1	Other: Injury a Work? 1 Ye	26. Place of 4 Nursir t s 2 No	ng Home 28d.	5 Residue la Describe la Substitution (Substitution (Subst	dence 6 how injury	Number of F	ecify) O Rural Route Num Ve	nber,
Division To the Hospital or Attentivitin 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle standard on the past of examination and manner stated.	edge, deat	h occurred at vestigation, in	my opin	ion, death o	lace, and occurred a	due to the time,	cause(s) a date and p	and manner a place, and du	as stated. le to the cause(s	s)
To with Coun	Σ	29b. Signatura and title of certifier Pollch	S	0.	C.M.			1		signed (Mon	2005	
Stat	0	31. Date filed (Month, Day, Year) 32. Alterar's Signatur	W)1	Print) 11 Pen	n St	reet,	Balt	imor	e, Ma	ryland	1 21201	L
Stat Registra		JAN 2 1 2005	6 1	9. 00								

			1- For Amend Item 18 State of Maryland / Department of Health and Me Registrar Certificate of Death		ne 005 01330
	Physici	an		2. Date of Death Month	Day Year 3. Time of Death
	/Media	al		Januar	y 16, 2005 7:55 PM
1	Examir	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I Under 24 Hrs. 8	B. Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country)
	Director		218 14 9676 14 1 1 81 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ct. 28,	1923 Maryland
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	with the Maryland is or 28a-f show Les notified at	ctor	Maryland N/A Baltimore		1∑Yes 2 □ No
	or 28	Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Country?
	death w	erai	1317 Church Street 21226 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	ifu Vac or No-	U.S.
21215-0036	or ite	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. H Yes, specify Cuban, Mexican, Puerto Ri H Yes, Specify Cuban, Puerto Ri H Yes, Specify Cuban, Mexican, Puerto Ri H Yes, Specify Cuban, Puer	ican, etc.)	Black, White, etc. Specify: White
5-0	72 hours 'natural', dical Ext	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16	b. Kind of Business/Industry
121	within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Cc	oast Guard Yard
	Hygi other ent, 1	e)	12th Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (Elsi)	First, Middle, Ma	iden Symame)
/lar	should be nd Mental marked o matic eve	To B	John W. Congleton, Sr.	e Rhineh	art
Maryland	and and is m		19a. Informant's Name/Relationship (Type, Print) Margaret Congleton / wife 19b. Mailing Address (Street and Number or Rural in the Name of Street) 1317 Church Street B		
	1 and Health em 27 ther tr		20a. Method of Disposition 20b. Place of Disposition /Name of Da	-	e, Maryland 21226 c. Location - City or Town, State
Baltimore,	Page:		1 ⊠Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery 1/20/2	2005 Ba	altimore, Maryland
Bal	permit. Departr Imports any inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gon 4001 Ritchie Highway	ce Funer Balti	cal Service, P.A. imore, Maryland 21225
	Pnysician /Medical Examiner		23s. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List eath one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):	s	, Approximate Interval Batween Onset and Death
68760, − ,	cate be executed physician and the burial-transit	dical Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
_	S G 8		IF FEMALE:		
P.O. Box	it the death certific by the attending p tached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delivery Month Day Year
ecords, P.	w requires that the second signed by should be detact		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of death?
α	The law ate has be	Completed		24a. Was an autopsy performed 1 Yes 2	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital: Other: O		
of		٠ <u>.</u>	27. Manner of leath 28a. Date of Injury 28b. Time of 28c. Injury at 28	e 5 ☐ Residenc d. Describe how	e 6 Other (Specify) injury occurred
ion	Attending P r death. sctor: After t by the funera	atio	1)√Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No		
Division of Vital	al or Atte s after de il Directo id in by th	Sertific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner, stated.	d due to the caus I at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	To the within To the complex c	Σ	29b. Signature and title of stiffier Search W 29c. License nymber 29c. License nymber 29c. License nymber	29d.	Date signed (Month, Day, Year)
	6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS BIOMO 3115, UMON WE HAD ME	2107	8
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature		

DHMH 17 Rev 1/2001

Congleton, John W.

ORIGINAL

1	,		1- State of Maryland / Department of Health and Mental Hygiene 0 0 5 0 1 3 3 1
	Physic /Medi		1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 1:32 pm
	Examir	ner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BON SECOUR 4c. County of Death N/A
	Funeral Director		5. Social Security Number Country Country
	e Maryland a-f show	tor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 10d. Inside City Limits 1 € Yes 2 □ No
	th with the 23a or 28.	ai Director	10e. Street and Number 2012 Raynor Avenue 10f. Zip Code 10g. Citizen of What Country? USA
900	within 72 hours after death with the Maryland ene. than "neturel; or items 23a or 28a-1 show to Mwitcel Examiner must be netitied at	d by Funeral	11. Marital Status 1
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. sd other than "neturel", or Items 23a or 28a-f show other than "neturel", or Items 23a or 28a-f show event, the Modical Examples must be neitlied at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade ONE Year 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Urban Services Agency
Maryland	2 should be filed within and Mental Hygiene. Is marked other than reumatic event, I'e M.	To Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elsie E. Johnson
	S 2 00 3		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shuron McLeod/Dawyhter 310 Randdph Way #303 Ellicott City MD 21043 20a. Wethod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If item 27 I: eny injury or other tre <u>once</u> .		12-Durial 2 Cremation 3 Hemoval from State LOUDON PARK D1. 24.05 Boultimore, MD
8	P P P P		21. Signature of Funeral Service Licenter Varying C. Greene Funeral Services 22. Name and Address of Facility Varying C. Greene Funeral Services 23a. Part. Enterth disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between interval Between
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death Onset and Death
8760, 17		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. GASTROINTESTINAL HEMORRHAGE Due to (or as a consequence of): HEPATIC FAILURE Due to (or as a consequence of): d. d.
.O. Box 68	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	hysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year 1 Yes 2 No 9 Unknown 1 Unknown 1 North Day Year 1 Yes 2 No 9 Unknown 1 North Day Year 1 No
rds, P	w requires that been signed by should be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
l Rec	The law ate has b page 2 sl	Completed	24a. Was an autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No
	Attending Physician: r death. ector: After this certific by the funeral director.	ertification: To Be	25. Was case referred to medical examiner?
5	tel or Attencts after death	Certific	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one) Check
)	To To	Σ	29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D3 1993 DAN 18 2005
	1		30. Name and address of person is completed cause of death (Item 23a) (Type, Print) EDWARD ROLLIANC MD 2000 W BALTIMORE ST
	Sta Registr		JAN 2 1 2005 JAN 2 1 2005 JAN 2 1 2005

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			_	1 10400 1	State of M	1aryland	/ Dep	artment of H	lealth a	nd Mer	ital Hyg	iene		
		1	For State Registrar					rtificate of				eg. No 2 ()	105	01332
	Physicia		1. Decedent's Name (F	irst, Middle, Last)	. 1	1	1.1	D - i			Date of Deat Month	h Day	Year	3. Time of Death
	/Medic	al	Marga	ret Jo	an	tenz	ell	De Le	r Location of		JAN	18 ZC	ty of Death	3:20A.M
	Examin	er	4a. Facility Name III no	Maria Maria		'/			Niom			BA	LTine	ORE
	Funeral		5. Social Security Number	ber 6. Sex		Age (In yrs. la		If Under 1 Year Months Days			Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign try)
	Director		Usual Residence of De	7720	M ZIMP	80	O Yrs.				11-26	-18	cng	land
	yland IOW	}		b. County		10c. City,	Town or L	ocation					1	Od. Inside City Limits
	e Mar	ctor	MD	BALTI	MORE		Tin	MONIUM	n					1 ☐ Yes 2 No
	with th	Funeral Director	10e. Street and Number		Valla	RJ		10f. Zip Code	1093	3	,	Og. Citizen of	- -	A.
	ms 23	neral	11. Marital Status	vlane	2. Was Decede	t Ever in U.S	S. 13.	Was Decedent of H			Yes or No-		ade - Americ ack, White,	
9	or Ita	y Fur	1 Never Married		Armed Force 1 ☐ Yes 2 ff Yes, Give	€ _{N°}		1 ☐ Yes 2 No	Specify:	, r dello i liot	ari, 610.)	Spec		
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itama 23e or 28e-f show ha Medical Everther mastice rollind at	ed by	3 Widowed 4	Divorced Decedent's Edu	Year or Dates	s: 	16a. Dece	dent's Usual Occur	pation		-	16b. Kind of	Business/In	dustry
715	nin 72 In "na Medic	Completed		only highest grad		or 5+)	(Give	kind of work done DO NOT use retire	during most d)	of working			1	
2	filed with Hygiene. Ather than	Com	10.			_	Hon	enake	19 Mathar	r'a Nama /F	iret Middle	Maiden Suma		nce
and	be fill ntal H ed oth	Be	17. Father's Name (Fir	st, Middle, Last)	20701	1			0	S Name (F	-	Sooth		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic avent, the Medical Evand or must be nothed at any injury or other traumatic avent, the Medical Evand or must be nothed at once.	ဥ	19ayInformant's Name	A/Relationship (Ty	pe, Print)		19b. Mail	ng Address (Street				City or Town	n, State, Zip	Code)
	1 and 2 Health a am 27 is		Hnthox	SYL.K	eating	- 20N	903	Farmi	steac	d Kd.	lock	CUSVI 20c. Location	lle, O	10 2/030 own, State
altimore,	Pages 1 nent of Ha int: If Itan		20a. Method of Dispos 1 Burial 2 DO 4 Donation 5	itio f i Cremation 3 □F	temoval from Sta	te ce	metery, cre	osition (Name of majory or other pla	100)	. 10	25			
Ë	permit. Pag Department Important: I any injury o		' 4 ☐ Donation 5			EVAL	JJ FUN	DERAL CHA 2. Name and Addr	PEL -	1-17.	-05	TIMA	of m	MOZIU3
Ва	permit. Departr Imports any inj		Dunk	outer la	San JAG	De	P	SKEFUL	ALTE	MATT	VES F	UDERI	ALCC	REMATION
	8		23a. Part1. Enter the shock, or heart for	disease, compl ailure. Li only o	ications that cous ne couse on ead	sed the death line.	. Do not en	ter the mode of dyi	ing, such as	cardiac or re	spiratory arr	est,	200	Approximate CT/C, Interval Between Onset and Death
	Physician		Immediate Cause (Fir disease or condition resulting in death)		DEMEN	TIA								
	/Medical Examiner				Due to (or	as a consequ	ience of):							
		ner	Sequentially list condi if any, leading to imme cause. Enter Underly	tions, ediate	b Due to (or	as a consequ	ence of):							
	be executed sician and burial-transit	Examiner	Cause (Disease or injusted events resulting in death) Las	ury	c. Due to (or	as a consequ	ence of):							
760,	te be executed ysician and e burial-transit	calE			d									
68	es that the death certificate be evigned by the attending physician be detached for use as the buria		15.551.41.5		v							7.11 8		-
Вох	death cer e attendir id for use	lan/N	23b. Was decedent print the past 12 mg	regnant ;		1 2 ☐ Fetal	death 3	Ectopic pregnanc	су				ate of deliverships and deliverships and deliverships and deliverships are deliverships and deliverships and deliverships are deliverships and deliverships are	ery Day Year
0.	the deay y the a	Physician/Med	1 ☐ Yes 2 🕱 N 9 ☐ Unknown		4∐Pregnan 9□ Unknow	t at time of de	atn 5	Other (specify)						ripet recordation
0	s that ned by e deta	y Ph	Part II. Other significa	ant conditions co	ntributing to deat	h but not resu	ılting in the	underlying cause g	iven in Part I.					he cause of death?
ords	w requires that been signed b should be deta	ted k									1□Y	es 2□No	3 🗌 Prot	oably 4 X Unknown
Records,	as b	Completed by									24a. Was a autop perfor	sy	prior to co death?	opsy findings available impletion of cause of
Vital F	iclan: The certificate har rector, page	e Col	25. Was case referred	to medical					26 Place	of Death (C	1 ☐ Yes Check only or	2 No	1 🗆 Yes	2 □ No
Ž	S .≅ ₽	To B	examiner?		Hospital: 1 ☐ Inp	atient 2 1	ER/Outpation	ent 3 DOA	thor	-		ence 6 🗆 O	ther (Speci	(y)
n of			27. Manner of Death	5 Pending	28a. Date of (Month,	njury Day Year)	28b. Time Injury	We			I. Describe h	ow injury occ	urred	
Division	Attending r death. actor: After by the fune	cati	2 Accident 3 Suicide	investigation 6 Could not be	28e. Place of	fnjury - At ho	me, farm, s	M 1 []Yes 2.∏i				nber or Run	al Route Number,
Div	pital or At	Certification:	4 🗍 Homicide	determined	building	, etc. (Specify	1)				City or Tow	m, State)		
	To the Hospital or Attent within 24 hours after deatl To the Funaral Diractor: completely filled in by the	edical ((Check only 2	Certifying Phy Medical Exam	iner: On the basi	s of examinat	wiedge, dea	th occurred at the nvestigation, in my	time, date an opinion, dea	d place, and th occurred	d due to the d at the time, d	ause(s) and r date and place	manner as s e, and due t	stated. o the cause(s)
	To the Hos within 24 h To the Fur completely	Medi	one) 29b. Signature and tit	le of certifier	and manner	r stated.		29c. Licer	nse number			29d. Date sign	ned (Month,	Day, Year)
	To With		•		-/0-			D	437:	25		11	119/0	5
	7		30. Name and address	s of person who o										
	7.00		DR. TAR 31. Date filed (Month)	IQ MAHMO				LLEY RD.	TIMO	NIUM,	MD 21	093		
	St Regist	ate trar		AN 2 1 2	005		M.	barle						

DHMH 17 Rev 1/2001

JANUARY 18, 2005 3:20 a.m.

MARGARET DELEY

State of Maryland / Department of Health and Mental Hygiene 2005 01333 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Downs 2:25 Am ame January 2005 /Medical Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Ba Dulance timore 1anor 100000 Are If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) 6 Sex Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 100 M 2□ F 220-14-7771 Usuel Residence of Decedent Yrs. Director 80 JARY Peges 1 end 2 should be filed within 72 hours efter death with the Marylend 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumetic event, the Modical Examinat must be notified at 1 ☐ Yes 2 No Directo BALTIMORE MARYAND 00050C 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? AVI 0 Funeral 500 NA 3138P 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. TXYes 2 No If Yes, Give Year or Dates: W. W. II 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 25 No Specify: <u>۾</u> 3⊠ Widowed 4 □ Divorced Specify: WHITE Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) ACHINE OPERATOR EYRS. IRE FACTORY 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Depertment of Health end Mentel Important: If Item 27 is marked o ARTHUR Jowns 1 IARGARET JAMIL 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) A1004 19a. Informant's Name/Relationship (Type, Print) 142 ARTHUR HAVE F. MARIL FRANCHIT DIPOSIT MARYLAND 20c. Location - City or Town, State 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date JAN. 22 ↑ Burial 2 Cremetion 3 Removal from State ANEY VALLEY EMETERY 4 Donation 5 Other (Specify), 2005 1 inonius 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

FEREFUL RYEROATING FURERALTERS 2322 YORK 16AO 1, MONEUM 91003 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Ceuse (Final diseese or condition resulting in death) /Medical BRUNCHOGOVIC CARCINOLINA MUNTHS Examiner Due to (or as a consequence of) Examine ettending physician end for use es the buriel-trensit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical Due to (or as a consequence of): ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No ABETES signed b WELLITUS 24b. Were autopsy findings available prior to completion of cause of death? certificate has been sirector, page 2 should 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes cese referred to medical exeminer? funerel director, Medical Certification: To Be 26. Place of Deeth (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA After this 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the funeral properties of the funeral pro death. 2 Accident 6 Could not be determined 3 D Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steled. 29a. Certifier To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) MO 0479h 2005 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) ALCEM 75 WD DRIVE MOLMOJ 15) io 31. Date filed (Month, Day, Year) 32. Registrer's Signature State JAN 2 1 2005 Registrar

1. Document Name (First Manual Auditor Manual Auditor) 1. Document Name (First Manual Auditor) 1. Special story Number (First Manual Auditor) 1. Manual Story Number (First Manual Auditor) 1.				For State Registrar	State of Maryland				ne 2005	01331
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The following is a second property of the control o	1215-00 Aithin 72 hou		npleted t	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	(Give kind of work doi life. DO NOT use ret	ne during most of workin ired)	g 16b.	Kind of Business/Ind	lustry
Approximate the disease or correspondence of the control of the co	and 21	antal Hygler cad other th c event, In	Be	17. Father's Name (First, Middle, Last)	^	SILF EMP				
Physician Medical Examiner 238. Part Letter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only department shock or heart failure. List onl		r Health ar item 27 is other trau	Ţ	19a. Informant's Name/Relationship (19a. Name/Relationship (19a. Name/Relationship (20a. Method of Disposition	Type, Print) 20b. Plant	ce of Disposition (Name of	RUST ORI	00,00 E	LERIVER	MO.
Physician / Modical Examiner The design of the design of completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, infinitial between charge and Death / Modical Examiner The design of the de	Baltimo	rtment rtant; I njury o		'4 Donation 5 ☐ Other (Specifi	Such State	NMERSE 22. Name and Add EVANS CH	EVRY 300	S Ma	Rentery Cary	WEST V4.
Course Enter Underlying Cause Enter Underlying Cause Enter Underlying Cause Inter Underlyin	/IV	ledical		Immediate Cause (Final disease or condition resulting in death)	a. fatalar	- by f Limic	tying, such as cardiac or	respiratory arrest,		Interval Between
FFEMALE 23b. Was decedent pregnant in the past 12 months? 1 1 2 1 1 2 1 2 1 2 2		sician and burial-transit		Cause. Enter Underlying Cause (Disease or injury that initiated events	C					
SO DO	Box 68 death certifica	attending pl for use as t	0	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 Live birth 2 Fetal de 4 Pregnant at time of deat	eath 3 Ectopic pregnar				,
24a. Was an autopsy performed? 25. Was case referred to medical saminer? 26. Place of Death Check on one 27. Manner of Death 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State) 28d. Location (Street and Number or Rural Route Number, City or Town, State)		06 g	þ	Part II. Other significant conditions c	ontributing to death but not resulti	ng in the underlying cause	given in Part I.			
The state of the control of the cont	I Rec	ate has page 2						autopsy performed?	prior to com death?	pletion of cause of
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)	on of	After this funeral di	ToB	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Bb. Time of 28c. In Injury W	Other: 4 Nursing Hom jury at 28 lork?	e 5 Residence		
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30. Name and address of person who completed colors of death (Item 23a) (Type, Print) Dr. DERWIND PHILLIP, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237	To the Hos	ompletely	Medica	one)	iner: On the basis of examination	n and/or investigation, in my	y opinion, death occurred	d at the time, date at	nd place, and due to t	the cause(s)
Dr. DERWIM PHILLIP, 9000 FRANKLIN SQUARE DRIVE, BALTIMORE, MD 21237) [7		30. Name and address of person who	completed car's e of death (Item 23	3a) (Type Print)		0	1/18/0	5
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar JAN 2 1 7005 Medica H. January			te	Dr. DERWIM PHILL 31. Date filed (Month, Day, Year)	IP, 9000 FRAN	KLIN SQUARE	E DRIVE, E	BALTIMORE	E, MD 21	237

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			1- State of Maryland / Department of Health and Certificate of Death		ene 005 0133	15
	Dhyaia	5.	1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of De	ath
	Physic /Medi			Januar	Day Year (31.1	ОМ
	Exami	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat		4c. County of Death	
		Ш	St. Hgnos Hospital Baltimore		n/a	
н	Funeral Director		5. Social Security Number 6. Sex 7. Age (In ŷrs. last birthday) If Under 1 Year If Under 24 Hrs 210–28–3715 12 M 2 F 67 Yrs. Nonths Days Hours Min.		9. Birthplace (State or For Country) Pennsylvania	
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	the N	Director	Maryland Anne Arundel Pasadena 10e. Street and Number		1 ☐ Yes 2[₹ No
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	death ma 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,	
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Baltimore,	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility ScCully—Polyniak F 32.04 Mountain Road			
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68760,	icate be executed physician and s the burial-transit	edical Examiner				
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Вох	death certifi e attending id for use as	n/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery	
	0 00	Physician/M	in the past 12 months? 1 Yes 2 No. 1 Yes 2 No.		Month Day Year	
P.0	at the	hys	9 □ Unknown			
	es be	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		cco use contribute to the cause of death	
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	Examin	er	4a. Facility Name (If not institution, give Harbor Hospital	street and number)		Ва	ltim					ty of Death	
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Baltimore, Maryland 21215-0036	be d all all all all all all all all all a	To Be	Joseph DiGiacomo)' Ange		inio)	
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mor	Pages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, cri Bayview (matory or of	ther place		Tanuar 21, 20	У	altimo		
alti	permit. Pages 1 and 2 should Department of Health and Mer Importent: If item 27 is marke any njury or other treumetic once.		21. Signature of Funeral Service Licens	pe)	_				•	ome Of			
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i			23a. Part1. Enter the disease or compl shock, or heart failure. List only or	ications that caused the cause of the cause on each line	he death. Do not e	nter the mode	e of dying	, such as	cardiac or r	espiratory arr	est,	,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Ne	tastati	c h	un	3 (anc	er			Ooset and Death
ş.	Examiner			B/L	consequence of):	mon	ias	J					3mos
	D ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	.,,,,,,,						-	-11100
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to /or as a	consequence of):								
8760,	cate be executed bhysician and the burial-transit	dicai E		1	consequence or).								
89	tificate ng phy as the	ledic											
Вох	eath certifications attending properties as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2		□Ectopic pre	egnancy					ate of delive	*
0	that the dea	Physician/Me	1 Yes 2 No 9 Unknown	4□Pregnant at tii 9□Unknown	me of death 5	Other (spe	ecify)				IV1	onth	Day Year
<u>ر</u> ت	es that the igned by be detact	by Ph	Part II. Other significant conditions cor	ntributing to death but	not resulting in the	underlying ca	ause givei	n in Part I.		23e. Did tot	oacco use cor	ntribute to the	e cause of death?
ords	w require been sig should b	ted t								1 🔀 Ye	es 2□No	3 🗌 Proba	ably 4 Unknown
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed							- 1	24a. Was a autops perform 1 Yes 2	y	Were autop prior to con death? 1 \(\sum \text{Yes} \)	sy findings available apletion of cause of
Vital	sicien: The certificate hir	Be	25. Was case referred to medical examiner?	la anital.					of Death	Check onl on			
of	Physic rthis or ral dir	. To	1 ☐ Yes 2 ☑ No ☐ 27. Manner of Death	lospital: 1 Inpatient 28a. Date of Injury	2 ER/Outpatie	-	A Other	4 Nur	-	5 Reside)
on	nding f ath. r: After e funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day)	Year) Injury	M	Work'			2. Describe no	JW IIIJUIY OCCU	rred	
Division of	l or Attendi after death. Director: A l in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	/ - At home, farm, s (Specify)	reet, factory,	office		28f	Location (St. City or Town	reet and Num. n, State)	ber or Rural	Route Number,
_	To the Hespital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	edical Ce	Check only 2 Medicel Examil	sician: To the best of ner: On the basis of e	xamination and/or i	th occurred a	at the time	a, date and	place, and	I due to the ca	ause(s) and mate and place.	anner as sta	ited. the cause(s)
	o the	Med	one) 29b. Signature and title of certifier										
	F 5 F 6		in	M.D.			D	544	-13		1/2	0/05	•
	9		30. Name and address of person who co	mpleted cause of dea	oth (Item 23a) (Type	Print)			K.	altin	ann n	10 "	7 17 7
	Sta	10	31. Date filed (Month, Day, Year)	Lee, 3	s Signature	Han	over	e x	- 4	wirn	VUL 1	IV C	1465
	Registra		JAN 2 1	2005	we to	7							

			1 - For State Registrar	State of M	aryland / I	Depa <i>Cei</i>	artment d <i>rtificate</i>	of He	ealth and	Mental Hy		Last C/ C/ L/	01337
	· ·		Decedent's Name (First, Middle, L.)	ast)			imodio	-	oui,,	2. Date of D	Reg. Neath	0.	3. Time of Death
	Physici /Medi		Patricia A.	Dishong						Januar		ay Year 2005	4:30 A ^M
	Examir		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Tov	wn, or Le	ocation of Deat		_	c. County of Deat	
			Genesis Nursing H	ome			Randa]	L1st	own			Baltimon	ce
	Funeral Director		5. Social Security Number 6. 216-60-5228	Sex 7. Ag 1 □ M 2 🖾 F	e (In yrs. last bii 53	rthday) Yrs.	If Under 1 Y Months D		If Under 24 Hrs Hours Min.		rth ay, Year 15,		nplace (State or Foreign untry) nessee
	p ,		Usuat Residence of Decedent										
	shov	2	10a. State 10b. County		10c. City, Tow								10d. Inside City Limits
	the M	Director	Maryland Baltin	nore	Cat	ons	ville						1 ☐ Yes 21K No
	with B or	급	1007 Rowe Land	_			10f. Zip Co				10g. Ci	itizen of What Co	untry?
	death ms 20	Funerai	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \		1228		necify Yes or N	0-	U.S.A.	ican todian
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notilized at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 反 Divorced	Armed Forces? 1 ☐ Yes 2 🖎! If Yes, Give Year or Dates:			Yes, specify		Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		Black, White Specify: Ame	rican
20	72 ho	ted	15. Decedent's E (Specify only highest gi	ducation	16a.	Deced	ent's Usual O	ccupatio	on		16b. K	Cind of Business/l	ndian ndustry
2	ithin 300.	Completed by	Etementary/Secondary (0-12)	College (1-4or 5	i+)	life. L	OO NOT use re	etired)	ring most of wor	rking			•
2	led w lygier her th	Co		2	Uni	.on	Repres				_	cial Sec	urity
and	l be fi	Be	17. Father's Name (First, Middle, Las Milton Moore	"						ne (First, Middle	, Maider	n Sumame)	
Ë	hould d Me mark matic	10	19a. Informant's Name/Relationship	(Time (Irint)	401	14.70			Mollie				
Ma	od 2 s Ith an 27 is trau		Timothy B. DeHoft									or Town, State, Zi	
ē	Heal Heal tem other		20a. Method of Disposition				Rowe La sition (Name of natory or other		Catons	Date		y land 21. ocation - City or T	
Baltimore,	Pages ent of nt; if i		1 ☐ Burial 2 🖾 Cremation 3 ['4 ☐ Donation 5 ☐ Other (Speci	Removal from State	1				1 2	2005		,	,
att	mit.		21. Signature of Ameral Service Lice		Nation				↑ 1 ∠∠ of Facility	4-2005	ra.	lls Chur	ch, VA.
m	Depa Impo sny ii		Me	M0/28	0	16	tzke Fi 30 Edmo	uner onds	ral Home son Aver	e of Cat nue Cato	onsv	ville, I ille, MD	nc 2 1 228
			23a. Part1. Enter the disease, or con shock, orbreart failure. List only	plications that caused one cause on each lin	the death. Do r	not ente	er the mode of	dying, s	such as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		tmmediate Cause (Final disease or condition	. END	STAC	9			DISE				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	10001		2 (20)	1) C			
	Zaminici	-	Sequentially list conditions,	b		0							
	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence o	or):							
· ·	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	a consequence o	of):		_					
68760,	ifficate be executed g physician and as the burial-transit	edicai		d									
		Medi	is service										
. Box	requires that the death certificate be executed een signed by the attending physician and hould be detached for use as the burial-transit	ician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome of 1 Live birth 4 Pregnant at	2 Fetal death		Ectopic pregna Other (specify					23d. Date of deliv Month	ery Day Year
л О	at the de	by Physici	9 Unknown	9□ Unknown									
	res tha igned l		Part It. Other significant conditions		it not resulting in	the un	derlying cause	given ir	n Part I.	23e. Did to	obacco u	use contribute to t	he cause of death?
0	w require been signal	eted	DEPRESSION	J				-		101	res 2	□ No 3 □ Prot	pably 4 2 Unknown
Records,	has has	ompieted							-	24a. Was autop perfo		24b. Were auto prior to co death?	ppsy findings available mpletion of cause of
Vital	ician: Th certificate rector, pag	O	25. Was case referred to medical					26	Rings of Deed	1 ☐ Yes	2 10 No		2 No
	y s	0 B	examiner?	Hospitat: 1 ☐ Inpatier	nt 2 ER/Out	patrent	3□ DOA			th (Check only o		6 □Other (Specif	
TO L	ding Ph th. : After thi funeral	on:	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	28b. T		28c. li	njury at Nork?	- Lap various g Tic	28d. Describe h	now injur	y occurred	y/
<u> </u>	tendir death. tor: Af the fu	atic	2 Accident investigation	1	700.7	iju i y			2 🗆 No				
DIVISION	i or Att after d Diract J in by t	ertificati	3 Suicide 6 Could not b 4 Homicide determined	28e. Ptace of tniu building, etc.	ry - At home, far . <i>(Specify)</i>	m, stre	et, factory, offi	се		28f. Location (S City or Tow	Street an vn, State	d Number or Rura)	il Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the funeral preserves.	edicai C	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exar	ysicien: To the best o niner: On the basis of and manner stat	examination and	death Vor inve	occurred at the	e time, o	date and place, on, death occur	and due to the o	cause(s) date and	and manner as s place, and due to	tated. o the cause(s)
	To th To th Compl	Me	29b. Signature and title of certifier				29c. Lice	ense nu	ımber		29d. Dat	te signed (Month,	Day, Year)
	eil de		blus, mp				000	DEG	107		01-	20-21	05
	12		30. Name and address of person who	completed cause of de	ath (Item 23a) (1	Гуре, Р	rint) 2615	0 4	135024	h \$ 1 (a -	7	-20-20 AVENUE	
	1		KAN U IIMA A IN	CLECANE ME	501/00 /	1 -	0	ALT	more	MD	21	215	
	Stat Registra	e ir	31. Date filed (Month, Ray Year) 1	2005 32. Reflistrat	r's Signature	G	parti						

			For State Registrar		State of M	Marylan		artment rtificate			nd Menta		ene g. No. O	05	01338
	Physic /Medi	cal		mES	DI	YOL)				Me	ite of Death onth	Day 12	Year 05	3. Time of Death //43 A M
	Examination Examin	ner	4a. Facility Name (III HOW AK 5. Social Security No. 218-82-9	20 Cou	NTY GEI	VERK	L HOST last birthday) Yrs.	O If Under	COL	Location of UMF	BIA 1	te of Birth onth Day,	17	9. Birthp Laur	RI lace (State or Foreign
	Maryland -f show	tor	Usual Residence of 10a. State MD	Decedent 10b. County Anne Aru	ındel		y, Town or Lo							1	0d. Inside City Limits
	th with the 23a or 28s	al Director	10e. Street and Num 1216 C	athedral	Drive			10f. Zip (Code 1061		-	100	g. Citizen of US	What Coun	try?
9036	be filed within 72 hours after death with the Maryland tal Hygiene. So other than "natural", or Items 23a or 28a-f show event, the Medical Exame acrinist be rotified at	d by Funeral	11. Marital Status 1 □XNever Marrie 3 □ Widowed		12. Was Deceder Armed Forces 1 ☐ Yes XI If Yes, Give Year or Dates	s?		Was Deceder f Yes, specif 1 ☐ Yes		spanic Origin , Mexican, F Specify:	n? (Specify Ye Puerto Rican,	es or No- etc.)	BI	ice - Americ ack, White, WHITE	
21215-	filed within 72 t Hygiene. other than "nati ent, the Medica	Completed	Elementary/Secon		ucation de <i>completed)</i> College (1-40	r 5+)	(Give life.	dent's Usual kind of work DO NOT use Labore	done de retired)	uring most o		С	onstr	Business/Ind	·
ryland	Mental Mental arked o	To Be	17. Father's Name (i Charles 19a. Informant's Na	Har	vey	Dixo		JR.		Jacq	Name (First, uelyn		Duf	£	
Baltimore, Maryland 21215-0036	es 1 and 2 of Health ar fitem 27 is r other trau		Jacquelyr 20a. Method of Disp	n DeBar	Mother Removal from Stat	20b. P		Beckn	el A	Ave Od	enton, Date 15-05	MD 21	113 c. Location	n, State, Zīp - City or Tor MORE , N	wn, State
Baltir	permit. Pag Department Important: f any injury o		21. Signature of Fun				22	. Name and	Address	of Facility	HOME	P.A.	12 RI	DGELY	AVE ANN,M
8760,	cate be executed /Medical Examiner up by scian and the brial-transit	dical Examiner	23a. Part1. Enter the shock, or heard immediate Cause (Fdisease or condition resulting in death) Sequentially list conif any, leading to immediate. Enter Under Cause. Enter Under Cause (Disease or in that initiated events resulting in death) Lie	ditions, mediate lying	a Cov Due to (or a	s a consequence ala s a consequence ala s a consequence ala	uence of): Leef uence of): Ue		4.0		foliac or respii		t,		Approximate Interval Between Onset and Death
.O. Box 6	that the death certific led by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 U 9 Unknown	nonths?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant : 9 ☐ Unknown	2 Fetal	death 3	Ectopic prec						te of deliver	y Day Year
Δ.	The law requires that it the has been signed by page 2 should be detain	by	Part II. Other signific	cant conditions co	ntributing to death	but not resu	Iting in the un	derlying cau	ise given	in Part I.	23	e. Did tobac	cco use con		cause of death?
	n: The law re licate has be r, page 2 sho	Completed									- _	a. Was an autopsy performed Yes 2	d?	prior to com death?	sy findings available pletion of cause of
ot	Attending Physician: The la r death. ector: After this certificate has by the funeral director, page 2	atlon: To Be	25. Was case referre examiner? 1 Yes 2 N 27. Manner of Death 1 Natural 2 Accident		Hospital: 1 Inpat 28a. Date of Inj (Month, D	ury	ER/Outpatient 28b. Time of Injury		Other: . Injury a Work?	4 ☐ Nursir	Death (Check g Home 5 [28d. De				
Divis	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Ir building, e	ijury - At hor tc. <i>(Specify)</i>	me, farm, stre	et, factory, o	office			ation (Stree or Town, S		er or Rural	Route Number,
	To the Hospital or within 24 hours afte within 24 hours afte To the Funeral Dir. completely filled in I	Medical	one)	Certifying Phy	sician: To the best ner: On the basis of and manner s	or examinati	vledge, death on and/or inv	estigation, in	my opir	nion, death o	ace, and due ccurred at the	time, date	and place,	and due to t	he cause(s)
•	7 A		29b. Signature and ti	relin	ompleted cause of	M. death (Item	23a) (Type. F		icense r		>		-	d (Month, D	2005 2006
	Sta Registr	٠.	K'Ambale 31. Date filed (Month)	Day, Year)	7845 (05 32.8	ars Signati	wood ure		0,10	03, (iley L	Burn	rie, r	402	1061

ORIGINAL

DHMH 17 Rev 1/2001

			1 - For State Registrar	State o	f Maryland /		artment rtificate			/lental	Hygie Reg.	40	05	01339
	Physic /Medi		1. Decedent's Name (First, Middle, Jean Lee De	ast) eVor	-					2. Date of Month	of Death	Day	Year 200 5	3. Time of Death
	Exami		4a. Facility Name (If not institution, g 3939 Roland Av				4b. City, To	_	ation of Death			4c. County		77700
	Funeral Director		21932-9863	Sex 1 ☐ M 21/21/4F	7. Age (In yrs. last 68	birthday) Yrs.	If Under 1 Months (Jnder 24 Hrs. ours Min.		n, Day, Ye	ar) 936	Coun	place (State or Foreign otry) yland
	Maryland f show	tor	Usuat Residence of Decedent 10a. State 10b. County Maryland 1	N/A	10c. City, To	_	cation Baltime	ore					11	0d. Inside City Limits 1 Yes 2 No
	with the 3a or 28a	Funeral Director	10e. Street and Number 3939 Roland Ave	nue Apt	. 713		10f. Zip C	ode	1211		10g.	Citizen of \	What Coun USA	itry?
980	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f show event, if a Mudical Examinat must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Notation 4 Divorced	12. Was Dece Armed Fo	edent Ever in U.S. rces? 2/12/No		Was Decedent f Yes, specify	nt of Hispan Cuban, Me	ic Origin? (Spexican, Puerto	ecify Yes o Rican, etc	or No-		ce - Americ ck, White, e	etc.
21215-0036	- 2	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 8th	Education trade completed) College (1		(Give life. I	lent's Usual C kind of work DO NOT use emaker	Occupation done during retired)	most of work	ing		. Kind of Bi	usiness/Ind	dustry
Maryland	should be filed within and Mental Hygiene. I marked other than umatic event, I a M	To Be C	17. Father's Name (First, Middle, La Richard Edmond F	*				18. [Mother's Nam	e (First, Mi			•	
	ulth ar 27 is r trau		19a. Informant's Name/Relationship Sherri Goodspeed						_{lumber or Run} ce West					Code) and 21211
Baltimore,	pernit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		20a. Method of Disposition 1 Burial 2 XCremation 3 4 Donation 5 Other (Specars) 21. Signatu at Tuneral Service Let	cify)	State 20b. Place ceme	of Dispo tery, cren	sition (Name natory or othe Nashi	of erplace) in ortor) 2005	20c.	Location -	City or To	wn, State
	Priysician /Medical Examiner		snack or heart failure. List on timmediate Cause (Final disease or condition resulting in death)	a. Chi	ch line.	65+1 e of):	er the mode o	re P	almo	or respirato	ry arrest,			211 Approximate Interval Between Onset and Death
68760,	icate be executed physician and the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Du to (or as a consequenc	e of):			77					
.O. Box 6	law requires that the death certifics as been signed by the attending pr 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1□Live bi	come of pregnancy with 2 Fetal dea ant at time of death wn		Ectopic pregri					23d. Date Mor	e of deliver	ry Day Year
Δ.	w requires that been signed by should be deta	by	Part II. Other significant conditions	contributing to de	ath but not resulting	in the ur	derlying caus	e given in F	Part I.		V		ribute to the	e cause of death?
al Records,	The ate h	Completed	25.M							a p 1 □ Ye	1	p d	Were autoportor to com death?	sy findings available apletion of cause of
n of Vital	ding Physician: 7. After this certifica funeral director, p	n; To Be	25. Was case referred to medical examiner? 1 Yes 2 Y No 27. Manner of feath	28a. ate o	npatient 2 ER/C	. Time of		Other	Place of Death Nursing Hole	me 5 🗆 F	lesidence	6 □Othe		
Division	Attendar death ector:	Certification;	Natural 5 Pending investigate 3 Suicide 4 Homicide	be 28e. Place	of Injury - At home, ag, etc. (Specify)	Injury farm, stre	М	1 Tyes			n (Street : Town, Sta		er or Rural	Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical C	29a. Certifier Certifying F	hysician: To the iminer: On the ba and mann	best of my knowleds sis of examination a er stated.	ge, death ind/or inv	occurred at ti estigation, in	he time, dat my opinion,	te and place, a death occurr	and due to ed at the tir	the cause ne, date a	(s) and mar nd place, a	nner as sta and due to t	ted. the cause(s)
)	To II comp	W	29b. Signature and title of certifier handaß	ed m	Ю		29c. Li	7P18	750		29d. D	ate signed	(Month, D.	ay, Year)
	٦,		30. Name and address of person who	RMD	of death (Item 23a	Type. F	Print)	y R	750 irkw	ay:	Bal	ltim	ore	MD
1 1 1	Sta Regístr	_	31. Date filed (Month, Day, Year)		gister's Signature	k_	book	,		l				

				f Maryland / Dep	artment of Health and National Artificate of Death	Mental Hygie		01340
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Joseph David DiPietr	o		2. Date of Death Month 01	Day Year 14 2005	3. Time of Death
	Exami		4a. Facility Name (If not institution, give street and num Shady Grove Hospital		4b. City, Town, or Location of Death Rockville		4c. County of Death Montgom	
	Funeral Director		5. Social Security Number 213-07-4117 Usual Residence of Decedent	7. Age (In yrs. last birthday) 94 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye 01-04-1		place <i>(State or Foreign</i> intry) nnsylvania
	e Maryland 8a-f show Iillied al	ctor	10a. State 10b. County MD Montgomery	10c. City, Town or Lo				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with th	al Director	10e. Street and Number 13200 Scarlet Mist Way		10f. Zip Code 20874	10g.	Citizen of What Cou	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic evant, the Midfell Examinate must be notified at anone.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Dece Amed Fo 1 Yes Silf Yes, Give Year or Divorced	2 🔼 No e	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
1215-0	within 72 ho ane. than "natur to Medical I	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1	-4or 5+) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16t	b. Kind of Business/Ir	ndustry
Maryland 21215-0036	uld be filed v Mental Hygie irked othar i itic evant, th	To Be Co	17. Father's Name (First, Middle, Last) Joseph D. DiPietro	Ste	eel Worker 18. Mother's Name Andrea	e (First, Middle, Mai	Building den Sumame)	
e, Mary	and 2 sho fealth and N m 27 is ma her trauma		19a. Informant's Name/Relationship (Type, Print) Carl DiPietro	1320	ng Address (Street and Number or Rura 00 Scarlet Mist Wa	y Germant	own MD 208	374
Baltimore,	iit. Pages 1 idment of h intant: If ita njury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 5 '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 7	Chesapea	natory or other place) ike Crematory 01-		Beltsville	
g G	permi Depa Impo any ii		23a Part J. Enter the disease, or complications that co	LONG.	2. Name and Address of Facility Rapp Funeral & Company State Silver the mode of dwing such as cardiac.	var Snrin	Services g MD 20910	Approximate
	nysician /Medical Examiner	8 10	Immediate Cause (Final disease or condition resulting in death)	ich line.	al Infraction			Interval Between Onset and Death 2 years
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events c.	or as a consequence of):				
68/60,	ificate be executed g physician and as the burial-transit	edicai	d.	or as a consequence of):				
C. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months?	int at time of death 5 □	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to de	ath but not resulting in the ur	nderlying cause given in Part I.		co use contribute to the	
		Completed				24a. Was an autopsy performed	prior to cor death?	psy findings available npletion of cause of 2 🖾 No
DIVISION OF VITAL	aing Ph h. After th funeral	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 No Pending (Month investigation)	patient 2 ER/Outpatien Injury 28b. Time of Injury	The state of the s		6 □Other (Specify	()
NINS	ital or Attand irs after death ral Diractor: led in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place	of Injury - At home, farm, stre g, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rura. ate)	l Route Number,
	Io tha Hospital or within 24 hours after To tha Funaral Dirac completely filled in b	Medical	one) 2 Medical Examiner: On the ba	sis of examination and/or inv	occurred at the time, date and place, a estigation, in my opinion, death occurre	ed at the time, date a	and place, and due to	the cause(s)
	S S S S S S		29b. Signature and title of Certifier	Mo	29c. License number D58681		Date signed (Month, 1 01-14-2005	Day, Year)
	1		30. Name and address of person who completed cause 9701 Medical Center Di 31. Date viled Mod ANV. 2ea1 2005 32.	. Rockville	Print) MD 20850			
	Sta Registr		21. Date ded Durch Hada. Cent. 5002	gistrar's Signature				

				State of Mar 23a per Dr	yland / Depa • ,G839,01	artment of H 121 /05dhl rtificate of	lealth and I Death	Mental Hygi	ene g. No. 20	05 0136
	Physic /Medi		Decedent's Name (First, Middle, La. Diana Ly	nn DiCato				JAN 8,	_	Year 3. Time of Death 10:37a M
1	Exami		4a. Facility Name (If not institution, given Anne Arundel Med			4b. City, Town, o	r Location of Death Polis	1	4c. County o	
	Funeral Director		, , , , , ,	ex 7. Age (i ☐ M 2 XF	In yrs. last birthday) 52 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day,	Year) 1952	9. Birthplace (State or Foreigr Calliornia
	show	5	Usual Residence of Decedent 10a. State 10b. County Maryland Anne A		Oc. City, Town or Lo					10d. Inside City Limits
	th the N or 28e-f e notifi	Director	10e. Street and Number	ruider	Cro	ofton 101. Zip Code		10	g. Citizen of Wh	1 ☐ Yes 2√☐ No nat Country?
	s 23e		1866 East Queens				1114		U	SA
920	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show to Medic Exercities man be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Dican, etc.)		American Indian, White, etc. White
21215-0036	in 72 hours "natural", ledical Ex:	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Deced	lent's Usual Occupa kind of work done of OO NOT use retired	ation during most of work	king 1	6b. Kind of Busi	ness/Industry
212	be filed within 72 h ital Hygiene. d other than "natu event, its Medica	Comp	Elementary/Secondary (0-12)	College (1-4or 5+)		ing Guard	1	(Government
Maryland	2 should be filed within and Mental Hygiene. Is marked other than raumatic event, It.e.M.	To Be	17. Father's Name (First, Middle, Last) David James				Betty	Anderson		
	nd 2 sh lith and 27 is m rtraum		19a. Informant's Name/Relationship (7) Thomas DiCato/hus					ral Route Number, Croftor		
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marke any injury or other traumatic. 000ce.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	20b. Place of Dispos cemetery, cren	sition (Name of natory or other place	9)	Date 20	c. Location - Ci	ty or Town, State
altir	permit. P Departme Importen any injur.	İ	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	1		ematory,		10/05 of Maryl	Baltimo	ore, MD
8	20 E 29 9	. 49	Thomas Gr	egor		299 Frede	erick Roa	d Baltin	ore MI	21228
A	Pnysician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a	Liv	er failure		or respiratory arres	t,	Approximate Interval Between Onset and Death MON (4) \$
	Examiner		ſ	Due to (or as a co		oho1				
90,	ficate be executed physician and s the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a co						
P.O. Box 68760,	death certii e attending d for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 21 No 9 Unknown	d	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	
rds, P	The law requires that the dite has been signed by the sage 2 should be detached	þ	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the un	derlying cause give	n in Part I.			ite to the cause of death? Probably 4 Unknown
al Records,	The lay	Completed						24a. Was an autopsy performe	d? prio	re autopsy findings available r to completion of cause of th? Yes 2 \(\subseteq \) No
of Vital	d is	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🖔 No	Hospital:	2 ☐ ER/Outpatient	3□ DOA Cthe		n <i>(Check only one)</i> me 5 ☐ Residend	e 6 □Other /	Specify)
Division o	fing After fune		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injury Work	at ?	28d. Describe how		Эрвспу
Divi	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre pecify)	et, factory, office		28f. Location (Stree City or Town, S	et and Number o State)	or Rural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier 1 X Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of money: On the basis of exa and manner stated.	y knowledge, death mination and/or inve	occurred at the time estigation, in my opi	nion, death occurr	and due to the caused at the time, date	e(s) and manne and place, and	er as stated. due to the cause(s)
	To th comp	Σ	- V	Beck, My			6052		1/9/0	fonth, Day, Year)
			30. Name and address of person who co	empleted cause of death	(Item 23a) (Type, P	Pouhwa	zy anua	polis ou	3	
	Sta Registra	e '	JAN 2 1 2005		Signature		7	. ,		

			For State Registrar	State of M	aryland		artment of H rtificate of L		nd Mental H	ygiene Reg. No	1115	013	42
	Physicia /Medic		1. Decedent's Name (First, Middle, L	Drumu	oriak	\uparrow			2. Date of I Month Januar	Day	200 5	3. Time of	O _{a M}
	Examin	er	4a. Facility Name (If not institution, g 610 Wildwood Park	ive street and number) Way	,		4b. City, Town, or Baltimo	re			County of Death		
	Funeral Director		5. Social Security Number 6. 216-36-7772 Usual Residence of Decedent	Sex 7. Ag 1 M 2 □ F	ge (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of 6 (Month, 10)	3irth Day, Year) .939	9. Birth Cou Mary La		r Foreign
	Maryland f show	or	10a. State 10b. County MD NA		10c. City	y, Town or Lo						10d. Inside Ci	•
	with the Page or 28a-	Direct	10e. Street and Number 610 Wildwood Park	wav			10f. Zip Code	.229		10g. Citi	izen of What Cou	ntry?	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, The Medical Exactle at most ke motified at ange.	by Funeral Director	11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces	Ever in U. ? No		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	spanic Origi n, Mexican, Specify:	in? (Specify Yes or I Puerto Rican, etc.)	No-	14. Race - Ameri Black, White, Specify:	etc.	
Maryland 21215-0036	within 72 hou lene. 'than "natura i'te Medical E	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0·12)		5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired Painter	turina most o	of working		ind of Business/Ir	ndustry	
land 2	uld be filed Aental Hyg rked other tic event, I	To Be C	17. Father's Name (First, Middle, La Leroy Johnson	st)	'				s Name (First, Midd		Sumame)		
Mary	alth and N		19a. Informant's Name/Relationship Diane Drumwright Owe						or Rural Route Num			Code)	
Baltimore,	Pages 1 and nent of He ant: If Item		20a. Method of Disposition 1 ABurial 2 Cremation 3 14 Donation 5 Other (Spec			lace of Dispo emetery, crei Zion Ce	osition (Name of matory or other place emetery	1	Date 1-22-05		sdowne, MD	own, State	
Balt	permit. Departi import. any inj once.		21. Signature of Funeral Service Lic	Jones)		W		l Home I	P.A. 638 N.		St. Balto		
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	in blications that cause by the cause on each in the cause on each in the cause on each in the cause of the c	TAT	ic	ter the mode of dying	g, such as ca	ardiac or respiratory	arrest,	MA	Approximate Interval Bett Onset and D	ween
8760,	cate be executed physician and sthe burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	s a consequ	LA()	URE						
.O. Box 6	death certific e attending p id for use as	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	Ideath 3[Ectopic pregnancy Other (specify)			-	23d. Date of deliv Month	,	/ear
Division of Vital Records, P.	aw requires is been sign 2 should be	Completed by Physician/Medical	Party Other significant conditions STRUKE Chyonic ob	s contributing to death		0(nderlying cause give		Leasta. w	Yes 21 as an topsy rformed?	No 3 Prol 24b. Were auto prior to co death? 1 Yes	pably 4 DU	Jnknown
f Vita	Physician: this certific ral director,	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpat	ient 2 🗆	ER/Outpatier	nt 3□ DOA Othe) F	of Death (Check only		6 ☐Other (Special	(y)	
sion o	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	ho	ay Year)	28b. Time o Injury	M 1	rat ⟨? Yes 2 □ N					
Divis	Hospital or Att 24 hours after de Funeral Direct stely filled in by t		4 Homicide determine	building, e	tc. (Specify	v)	reet, factory, office		City or 1	own, State			oer,
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis and manner s	of examinat	wledge, deat tion and/or in	vestigation, in my op	oinion, death	place, and due to the control occurred at the time	e, date and	place, and due t	o the cause(s)	
}	Vitt Con	2	29b. Signature and title of certifier	Lucy	Ma		29c. License	39	87	J.P.	te signed (Month,	20 g	1005
	5		30. Name a d address of grson wh	Gh. 3	100	Marie	Print)	1	11 39	Bat	laine 1	121	20/
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 1		trar's Signa	J. J.	park		,				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year 4:45 pM Doris 19, E. Eschenbach January 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Pasadena nder 1 Year | If Under 24 Hrs. Cranberry Cottage Assisted Living Anne Arundel **Funeral** 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🔀 F Director 190-18-2834 81 26,1923 | Pennsylvania Usual Residence of Decedent filed within 72 hours after death with tha Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 K No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 698 213th Street Funerai 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 If Yes, Give Year or Dates: 1 Yes 2 No þ Specify: Specify. 3 Widowed 4 Divorced "naturel", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene. markad other than Elementary/Secondary (0-12) College (1-4or 5+) N/A Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should ba f nent of Health and Mental I ant: If item 27 is markad o Fred 2 Logan Dorothy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Wood (Daughter) 698 213th Street Pasadena, Maryland 21122 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State = 0 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 1/22/05 Glen Burnie, Maryland 21. Signature of Fune al Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Uleni 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arterisclass disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Physician/Medical Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury or Attending Physicien: The law requires that the death certificate be exacuted burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Month Year 5 Other (specify) P.0. the detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ page 2 should be Completed 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes No autopsy performed? 30 No 1 Yes 2 XV0 director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Leath 28b. Time of 28d. Describe how injury occurred After 5 Pending death. 2 Accident investigation 1 Yes 2 No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 0 5 10 rson who completed cause of death (Item 23a) (Type, Print) Name and add WY 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

			1 - For State Registrar		State of	Maryland	/ Depa	artmen rtificate	t of H	lealth a	and M	lental H	ygien Reg. N	E U () 5	01	344
	Physic	ian	1. Decedent's Name (F		t)							2. Date of I		ay ,	Year	3. Tim	ne of Death
	/Medi		Avis Euri									Jan		6th	2005	1	TOOM
4	Exami	ner	4a. Facility Name (If no:		street and numb	per)		4b. City,	Town, or	Location	of Death		4	c. County	of Death		,
	Funeral		5. Social Security Number	1es 6. Se	1 tauth	Age (In yrs. las	t hinthday)	If Under	1 Year	If Under	24 Hrs.	9 Date of F	lieth		N/		
	Director		219-07-923	18]M 2∏xF	84	Yrs.	Months	Days	Hours	Min.	8. Date of E (Month, I May 2	Da <i>y, Yea</i>	920	Coun	itry) ylan	ate or Foreign
	pu ,		Usual Residence of De	cedent							1	1.00		720	1141	yran	iu .
	anyla show	-		b. County		10c. City, 1	fown or Lo	cation							1		e City Limits
	the M	ecto	MD 10e. Street and Number	Balti	nore				butu	ıs							Yes 2 No
	with with	급	5000 Westl		1			10f. Zip		227			10g. C	citizen of V		,	
	ns 23	era	11. Marital Status	and bive	12. Was Deced	ent Ever in U.S.	13 1	Was Deced		227	gin? (Soe	oity Voc or h	la.		ed S		
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Itams 23a or 28a-f show or other traumatic event, the Medical Evant at must be multiped at	by Funeral Director	1 □ Never Married 3 ☒ Widowed 4 □	_	Armed Forc 1 Tes 2 If Yes, Give Year or Date	es? KjiNo		f Yes, spec		Specify:		ecify Yes or N Rican, etc.)	10-		k, White,		٦,
5	72 h	etec	15. (Specify o	Decedent's Edi	ucation de completed)		6a. Deced	dent's Usua kind of wor	l Occupa	ition	t of workir	na	16b.	Kind of Bu	siness/Inc	lustry	
121	within ne.	Completed	Elementary/Secondar		College (1-4	or 5+)		kind of word			. 0, 1,0,1,1,1	9					
	filed v Hygie other t		8 17. Father's Name (Firs	t Middle Last)			Sa	les C	lerk		r's Nama	/Eimt Midd	lo Maida	Ret			
Maryland	d be antal	To Be	Charles Ko									(First, Middi	e, Maige	n Sumam	θ)		
$\overline{\mathbf{z}}$	should ind Men s marka umatic	Ĕ	19a. Informant's Name		ype, Print)		19b. Mailir	a Address	(Street a		dna (Lay I Route Num	her City	or Town	State 7in	Code	
	alth a 27 is		Denise McAl	Lexander	Daugh							butus				0000)	
Je,	of Her item		20a. Method of Disposit	ion		20b. Plac	e of Dispo	sition (Nam	ne of			ate		Location -		wn, State	9
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any njury or other tra once.		4 Donation 5	remation: 3 ∐f]Other <i>(Specify,</i>		41H	-	rk Ce			L - 19-	-2005	Bai	ltimo	re. N	4D	
atti	permit. Pa Departmen Important: any njury		21. Sature Funera	al Service Licenç	CAN S	m						se Fur					
<u> </u>	89 5 8 9		COSTU	Mulh) (CC)	wh	2	719 H	ammo	nds E	erry	Rd.,	Lans				227
			23a. Part1. Enter the di shock, or heart fai	isease, or comp ilure. List only o	lications that cau ne cause on eac	sed the death. Y	Do not ente	er the mode	of dying	, such as	cardiac o	r respiratory	arrest,				nate Between
	Physician	0.0	Immediate Cause (Fina disease or condition	al	. DI	(Onset a	nd Death
	/Medical Examiner		resulting in death)		Due to (or	as a consequen	ce of):		1							2.02	ays
	Lxammer	_	Sequentially list condition	ons,	. Aci		enal	1	-ai(ure						24	ecks
	ted rsit	nine	Sequentially list condition if any, leading to immediate. Enter Underlyin Cause (Disease or injur	glate	Due to (or	as a consequen	ce of):									214	ente
	cate be exacuted thy sician and the burial-transit	Examiner	that initiated events resulting in death) Last		c. Due to (br	as a consequen	ce of):									200	CERS
8760,	siciar b burii	dicai E			. Pn+	eumon	ı'a									2 4	eeks
9	tificat ig phy as the	ledic		-	<i>y</i> . —												
О. Вох	The law raquires that the death cartificate be exacuted the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 □ Yes 2 → Yo 9 □ Unknown	iths?		n 2 ∏Fetal de t at time of death	ath 3□	Ectopic pre Other (spe						23d. Date Mon		ry Day	Year
σ.	res that igned by be deta		Part II. Other significan	t conditions co	ntributing to deat	h but not resultin	g in the ur	derlying ca	use givei	n in Part I.		23e. Did	tobacco	use contri	bute to the	a cause	of death?
rds	w raquires been sign should be	ed by	_ Hepat	itis C								1 🗆	Yes 2	No :	3 🗌 Proba	ibly 4	□Unknown
တ္တ	aw ranga sa	Completed	Cinho	5,0								24a. Wa:	an	24b. W	ere autop	sv findin	gs available
R	The I	Ho				***							ormed?	pr de	for to comeath?	pletion o	of cause of
Vital Records,	sician: Th certificate rector, pag	BeC	25. Was case referred to examiner?	o medical						26. Place	of Death	1 Yes	2.24No	- 11	JYes 2	SIXNO	
of V	Physician: this certific al director,	10	1 ☐ Yes 2. No	ŀ	lospital:	atient 2 ER/	Outpatient	: 3□ DOA	Othor			ne 5□Res		6 Othe	(Specify)		
Division o	ding After funer	Certification;	2 Accident	Pending investigation	28a. Date of I (Month,	njury 28 Day Year)	b. Time of Injury	M 28	lc. Injury Work' 1 Y	at ? es 2 □ N		8d. Describe	how inju	iry occurre	d		
Divi			4 Homicide	Could not be determined	building,	Injury - At home etc. (Specify)						8f. Location City or To	wn, Stati	Θ)			umber,
	To the Hospital or within 24 hours after To the Funeral Discompletely filled in	ledical	29a. Certifier (Check only one)	Medicel Exemi	sicien: To the be ner: On the basis and manner	s of examination	dge, death and/or inv	occurred at estigation, i	t the time in my opi	e, date and nion, death	d place, ar h occurre	nd due to the d at the time	cause(s date an) and man d place, ar	ner as sta nd due to t	ted. the cause	9(\$)
)	with To	X	29b. Signature and title	of certifier	m.	M		29c.	License	number	10			ite signed			
	4		30. Name and address of	of person who co	mpleted cause of	of death (Item 23	a) (Type, F	Print)	1 1	30				W1, [UITI	200	ے۔۔۔۔
	1		YISUN	V, 90	OS Ca	ton A	ve,	Ba	Hi	MOH		MD	21:	229)		
	Sta		31. Date filed (Month, D	li Ab	32. Regi	yar's Signature	7							1			
	Registr	÷		V 2 1 20	05	en b	-	-									
DHM	MH 17 Rev 1/20	001			- P		IGINA	L									

PIERRE FORRESTER 05-00432 RKD

			1 - For State Registrar	State of Ma	ryland		artment rtificate					Reg. No.	200	5 013	345
	Physici		Decedent's Name (First, Middle, Last) Pierre			H	orres	ster			2. Date of De. Month JANUAR	Day	2005	3. Time of t	
>	/Medic Examin		4a. Facility Name (If not institution, give s JOHNS HOPKINS HOSP)				4b. City, BALT		Location o	of Death	Oz HVOZ IZV		ounty of De		
	Funeral Director		5. Social Security Number 218–98–7580 6. Sex 1 D	M 2TF	(In yrs. las	Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 10-24	h y, Year) -81	9. E	Birthplace (State or Country) Md	
	show	-	10a. State 10b. County Md. NA			Town or Lo						· · · · · · · · · · · · · · · · · · ·		10d. Inside City	•
	th the M or 28e-f e nutifie	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What		
	ath wi	ral	1419 N. Central A					2120					USA		
36	filed within 72 hours atter death with the Maryland Hygiene. ther than "natural", or Items 23e or 28e-f show ont, Ite Madical Exactronal be natified at	by Fune	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		- 1	Was Deced f Yes, spec 1 ☐ Yes 2		spanic Origin, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		Black, Wi	merican Indian, hite, etc. Black	
21215-0036	d within 72 hours piene. r than "naturel", Ire Medical Ex-	Completed	15. Decedent's Educ (Specify only highest grade	completed)		16a. Deced (Give life. L	dent's Usua kind of wor DO NOT us	l Occupa k done di e retired)	tion uring most	t of worki	ing	16b. Kind	of Busines	ss/industry	
212	d withir giene. er than	Com	10th grade	College (1-4or 5-	+)	Une	mploy	red				N	A		
and	ed ital	To Be (17. Father's Name (First, Middle, Last) Quentin	Linnin	gham					r's Name Chel	ı (First, Middle, 1e		_{umame)} 'orres	ter	
Maryland	s 1 and 2 should be 1 f Health and Mental I item 27 Is marked o other traumatic eve		19a. Informant's Name/Relationship (Type Geraldine Weaver				•				Baltim			, Zip Code) 21202	
	es 1 and 2 of Health of Item 27 I r other tra		20a. Method of Disposition		20b. Plac	ce of Disponetery, cren	sition (Nam	ne of	1)ate			or Town, State	
Baltimore,	Page tment tent: If jury o		1 Burial 2 Cremation 3 Re '4 Donation 5 Other (Specify)		Kin	g Mem					4-05	Ran	dalls	town, Md	
Ba	permit. Pages I Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service License	wan	رم	1	March			_	Bal 1101	timor E. No	e, Md rth A	. 21202 ve.	
8760, -\	Medical Examiner buysician and street burial-transit	dlcal Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. First indeptying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	consequer		ush	<i>⊙</i> /	W.	- e al	2			Approximate Interval Betw Onset and Di	eath
P.O. Box 6	he death certif the attending thed for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	2 ☐ Fetal de	eath 3	Ectopic pre Other (spe					23	d. Date of d Month	,	ear
	uires that the signed by detaction	by	Part II. Other significant conditions con	tributing to death but	t not resulti	ing in the ur	nderlying ca	iuse give	n in Part I.			bacco use		to the cause of de	
Division of Vital Records,	ician: The law requires certificate has been sign rector, page 2 should be	e Completed	OF Was one selected to medical								1 Yes	rmed? 2 \(\text{No} \)	24b. Were prior to death'		vailable use of
Ξ	ysician: is certific director,	To Be	25. Was case referred to medical examiner? 1 XYes 2 No	ospital:	nt 2X EP	3/Outpatien	t 3 DO	A Othe			n <i>(Check only o</i> me 5 ☐ Resid		Other (Sc	oecify)	
n of	ng Phy ter thi		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury Month, Day	/ 28	8b. Time of Injury		Bc. Injury Work	at ?	2	28d. Describe h			,,	
Divisio	or Attending after death. Director: After in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injurbuilding, etc.	ry - At home (Specify)		eet, factory,	office	es 2 (City or Ton	m, State)	1400 K	Rural Route Numb	ier,
_	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	icien: To the best of er: On the basis of and manner stat	examination	edge, death	occurred a	at the time				cause(s) ar	nd manner		
	To the To the Complex	X	29b. Signature and title of certifier	1 X	1 21	. ()	29c.	O.C.	number M.E.				signed (Mo	nth, Day, Year) , 2005	
	4	•	30. Name and address of person who cold the state of the	King				PENN	STRE	ET B	ALTIMOR	RE, MAE	RYLANI	21201	
	Sta Registr	_	JAN 2 1 2005	2. Registral	100	100									

		For State Registrar	State of Marylar		ertificate of	Death	Reg. No	2000	01346
Physici /Medi		1. Decedent's Name (First, Middle, L	//	RANG			2. Date of Death Month Da	9 2005	3. Time of Death
Examir Funeral Director		4a. Facility Name (If not institution, g i Christ 5. Social Security Number 6. 218-441-9960	ive street and number) ON TCR Sex 7. Age (In yrs.	last birthda 59 Yrs.	Tow	T Location of Death SON If Under 24 Hrs. 8 Hours Min.		C. County of Death OALTT/ 9. Birthp Coun MAR	lace (State or Foreign
		Usual Residence of Decedent 10a. State 10b. County		ty, Town or					0d. Inside City Limits
death with the Maryland ms 23a or 28a-f show rmust be notified at	Directo	10e. Street and Number	TIMORE	BH	LTIMO RO		10g. C	itizen of What Coun	1 Yes 2 No
	/ Funeral Director	11. Marita/Status 1 Never Married 2 Married	12. Was Decedent Ever in U	J.S. 13		1034 dispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	ify Yes or No- can, etc.)	14. Race - Americ Black, White,	
Z 21215-0036 d 21215-0036 Hygiene. Ither than "naturel, or he internities out, the Medical Examina	leted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's (Specify only highest g	Education	(Gi	edent's Usual Occur	ation during most of working	16b. F	Kind of Business/Inc	JUSTRY .
Ind 2121 be filed within tal Hygiene. d other than event, tram	e Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	0	1es	18. Mother's Name (e lemar Sumame)	keting
E ad la la la la la la la la la la la la la	To Be	William R. H 19a. Informant's Name/Relationship	FRANCK, SR.	19b. Ma	iling Address (Street	Anna and Number or Rural I	Hamil Route Number, City	or Town, State, Zip	Code)
		TERRI BOB/000 20a. Method of Disposition	1 /	190 Place of Dis	Haver position (Name of ematory or other place	hill Rd. B	ALTIMOR 10 20c. L	Ocal ion - City or To	21234. wn, State
Baltimore, Baltimore, permit. Pages 1 at Department of Hea Important: If item any injury or othe		1 Burial 2 Cremation 3 4 Donation 5 Other (Special Signature of Funeral Service Lice	city) Du	aneyV	11 PUMPMC 22. Name and Addre	301 OPUS 1-6 ss of Facility 2325	YORK RDST	HONIUM ,	MD 21093.
00 80E88		23a. Part1. Enter the disease, or co shock, or heart failure. Ust on	mplications that caused/the deal	th. Do not e	DEFECT A	ng, such as cardiac or	respiratory arrest,	7.	Approximate Interval Between Onset and Death
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a		ic ren	al peli	res care	insum	months
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	quence of):					
68760, filicate be executed g physician and as the burial-transit		that initiated events resulting in death) Last	c. Due to (or as a consequence)	quence of):					· · · · · · · · · · · · · · · · · · ·
C 6870 srtificate ling physis	Medicai	IF FEMALE:			-		1		
Records, P.O. Box 687. The law requires that the death certificate the has been signed by the attending physicage 2 should be detached for use as the law and the law and the law and the law and the law and	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of confidence of the second secon	al death 3	☐Ectopic pregnancy ☐ Other (specify)	′		23d. Date of delive Month	ry Day Year
cords, P	b	Part II. Other significant conditions	contributing to death but not res	sulting in the	underlying cause giv	en in Part I.		use contribute to th	e cause of death? ably 4 []Unknown
	Completed						24a. Was an autopsy performed?	prior to con death?	osy findings available inpletion of cause of
Vision of Vital Ratending Physicien: The refeath. ector: Attenthis certificate to the funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpati 28b. Time Injury	of 28c. Injur	y at 28		6 Other (Specify	Hospice
Division of or Attending s after death.	Certification;	3 Suicide 6 Could not determine	building, etc. (Special	fy)	•		f. Location (Street a City or Town, State	θ)	
DIVI To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	one)	Physician: To the best of my kno aminer: On the basis of examina and manner stated.						
	Σ	30. Name and address of person when the state of the stat	my liley.	and	29c. Licens	e number	29d. Da	ate signed (Month, I	(2005)
9	1	30. Name and address of person wh	o oppopleted cause of death (Iter	m 23a) (Typ	V. Chac	Co St. F.	ra Cto. M	1212	96
Sta Regist	1.0	1 /1 1 / -	32. Pigistrar's Signa	H. M	books				

		Į.	For State	State of M	laryland		artment o			Mental		Alle de co	p-ma	0101=
	Physici		1. Decedent's Name (First, Middle, Lateral Corinne T. Fritz				imouto	01 00		2. Date of Month	D:	ay)	(ear_	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give		7)		4b. City, To	vn, or Loca	ation of Dea	ath		8 (c. County of	Death	11.43 ^{41.M}
			Holy Cross Nursin	ng & Rehal).		Burt	onsy	ille		P	rince		
	Funeral Director	1	5. Social Security Number 6. S 220–20–3293	6ex 7.A I□M 25/20xF	ge (In yrs. Ia 77	st birthday) Yrs.	If Under 1 \		Jnder 24 Hi ours Mi		n, Day, Year	927	Count	* /
9			Usual Residence of Decedent							• دست	20, 1	741		yland
arvlar	show	5	10a. State 10b. County			Town or Lo							10	0d. Inside City Limits 1 ☐ Yes 2√☐ No
the M	28a-f	Director	MD Montgon	nery	Sir	ver Sp	oring 10f. Zip Co	de	·		10g. C	itizen of Wh	at Count	
h with	23a or st be		12007 Kempmill F	Road			20	902				USA		
r deal	er mi	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?	13.			ic Origin? exican, Pue	(Specify Yes of orto Rican, etc	or No-	14. Race -	America White, e	
5-0036 72 hours after death with the Maryland	an "natural", or items 23a or 28a-f show Medical Examinar must be notified at	þ	1 ☐ Never Married 2 💆 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates			1 ☐ Yes 2 🔀	No Sp	ecify:			Specify:	W	hite
21215-0036 ad within 72 hours af	natur dical f	Completed	15. Decedent's Ed (Specify only highest gra			(Give	dent's Usual C	one during	most of w	orking	16b. l	Kind of Busi	ness/Ind	ustry
121 within	r than	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)	Asst.	Marke	ting	Manag	ger	TA7: 7	liamo	9. Ta7·	ilkins Co.
d 2	Hyg other ant, I	Be Co	12 17. Father's Name (First, Middle, Last)	6		TOI	Clini			ame (First, Mi				IIKIIIS CO.
arylan should be	Mental arked c	To B	Harrison Tongue					L	illiar	n Kelly	7			
_ <	and a m		19a. Informant's Name/Relationship (Cindy Foltz - nie	•			•			Rural Route N				Code)
	Hea the		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name	of	Reis	Stersto Date		D 21.		vn, State
MOI	522		1 ☐ Burial 2 X Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif		9 _		matory or othe Wash.		1/2	3/2005	Lau	rel,	MD	
Baltimore,	Department Important: I any injury o		21. Signature of Funeral Service Licer	10.0-		22	2. Name and A	ddress of	Facility					dge MP, Inc.
ш	0 = a a		23a. Part1. Enter the disease, or com	olications that cause		72	250 Was	hinat	on B	Vd. F	lkrid	ge, M	2	1075 Approximate
		-	shock, or heart failure. List only	one cause on each	line.			dynig, su	on as cardi	ac or respirate	ny arrest,			Interval Between Onset and Death
	hysician /Medical		disease or condition resulting in death)	a. Gliobl	s a conseque		aın						1	Yr.
Ε	xaminer		Sequentially list conditions,	b										
ted	nsit	Examlne	cause. Enter Underlying Cause (Disease or injury	Lua to (or a	e a eoneuqua	inea cty:								
0,	sician and burial-transit		that initiated events resulting in death) Last	Due to (or a	s a conseque	ence of):								
. Box 68760, death certificate be executed	physicia the bu	dlcal	(_ d										
ox 6	attending pl	0	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnan	су	11/2/2019					23d. Date	of deliver	v
. Bc	e atter	Physician/M	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Ect <i>o</i> pic pregi Other (speci				_	Month		Day Year
P.O.	detached	Phys	9 ☐ Unknown 1 Part II. Other significant conditions of		but not social	ting in the w	ndorhing onus	o gues is	Dort I	230 1	Did tobacco	usa contrib	uto to the	cause of death?
S S	p ed	5	Partit. Other significant conditions of	ontibuting to death	Dut Hot 163ah	ung in the di	noonying cads	e given in	ant ii				☐ Proba	
ecord	as been s 2 should	Completed									Mas an	24b. We	re autop	sy findings available pletion of cause of
—	ate h page	Com								1 🗆 Y	autopsy performed? es 2 🏻 No	dea	ath? Yes 2	
of Vital	certific	Be	25. Was case referred to medical examiner?	Hospital:				Othor		eath (Check o				
of F		. To	1 ☐ Yes 2 X No 27. Manner of Death	1 ☐ Inpat 28a. Date of Inj (Month, D		R/Outpatien 28b. Time of		Injury at Work?	Nursing	Home 5 1	Residence ribe how inju			
Vision	death. ctor: After y the funer	atlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	n	ay Year)	Injury	М	Work? 1 ☐ Yes	2 🗆 No					
Division or Attending	- i - i	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place of It	njury - At hon etc. (Specify)	ne, farm, str	eet, factory, o	fice			on (Street a Town, Stat		or Rural	Route Number,
Hospital	urs aral			nysicien: To the bes										
the Ho	within 24 ho To the Fun completely f	ledical	one)	miner: On the basis and manners		on and/or in				curred at the ti				
To	To To	Σ	29b. Signature and title of certifier	? Done	5/11/	1- mi	7	cense nun	nber			ate signed (
•	<	-	30. Name and address of person who	· Named	nall		∠1 ا بي	2121			J.	an. 19	9, 2	005
	\ X		JU, Maille allu audiessiel Deisoli Wild	completed cause of	death (Item 2	23a) (Type.	Print)							
	X		George F. Sengstac	ck, MD, 39	29 Fe	rrara		ilveı	Spri	ing, MD	209	06		

Replacement

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

			State of Ma	aryland / Depai <i>Cert</i>	rtment of F cificate of		ntal Hygier Reg. N	2016	-01348
-	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Imogene		Ge	erst J	an 20	Pey Year 2005	3. Time of Death 8:15 pm
	Examini Funeral Director		4a Fecility Name (If not institution, give street end number) CYON WELL 5. Sociel Security Number 214-22-4917 1 M 2 F	Home (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	Bald me if Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea	Baltimor Baltimor 9. Birthc Cour 918 Miss	•
	show	7	Usuel Residence of Decedent 10a. State 10b. County Market and Cooking	10c. City, Town or Loca		the state of the s			0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ith with the Marylen 23s or 28s-f show ust be notified at	Direc	Maryland Cecil 10e. Street end Number 328 Broad Street		10f. Zip Code	ryville 903	10g. (Citizen of What Cour	
020	urs after des el', or items Examiner m	by Funeral	11. Marital Status 1 □ Never Married 3 □ Wishowed 4 □ Divorced 12. Was Decedent I Armed Forces? 1 □ Yes 2 □ Wifyes, Give Year or Dates:	No .		lispenic Origin? (Specify an, Mexican, Puerto Rica Specify:	Yes or No- an, etc.)	14. Race - Americ Black, White, Specify: Wh	etc.
21215-0020	within ene. than	Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 10th Grade College (1-4or 5	(Give ki	ent's Usuel Occup ind of work done O NOT use retired maker	during most of working		Kind of Business/Ind	ustry
Maryland	al H	To Be C	17. Fether's Neme (First, Middle, Last) John Havrison			18. Mother's Name (Fi	2 Sm	ith	
	1 and 2 Health e sm 27 is		19a. Informant's Name/Relationship (Type, Print) Mr. Anthony Gerst (son) 20a. Method of Disposition	1	Box 726	end Number or Aurel Ac	Le, MD	v or Town, State, Zip 21903 Location - City or To	
Baltimore,	permit. Pages Depertment of I Important: If its any injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) Entombmen 21. Signature of Funeral Service Licensee	t Holly Hil	L Maus. Name and Addre	1/2 ss of Facility Schin	nunek Fu		
Alay.		-	23e. Part1. Enter the diseese, or complications that caused shock, or heart failure. List only one cause on each lir	the death. Do not enter		ur Rd., Bal ng, such as cardiac or re		MD 21236	Approximate Interval Between Onset and Death
	Physician /Medical Examiner	a	resulting in death)	Due to (or as a consequent		mia		1	
50,		i Examine	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury c.	Due to (or as e conseque	ence of):		·		
Box 68760,		an/Medicai	that initiated avenue	Due to (or as a conseque	ence of):				
P.O.	law requires that the deeth certifias been signed by the attending as been signed by the attending a 2 should be deteched for use e.	by Physician/M	Part II. Other significant conditions contributing to death but Alzheimers Dem	-	derlying cause giv	en in Part I.	23b. Did tobacc		the cause of death?
of Vital Records,	lay has	Completed b					24a. Was an aut performed?	avi co	are autopsy findings ailable prior to mpletion of cause death?
Vital F	clan: ertific	Be	25. Was case referred to medical examiner?		2□ DOA Oth	26. Place of Death (Cl		1	Yes 2 No
	S v D	ation: To	1 ☐ Yes 2 ☐ No 1 ☐ Inpatie 27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation 1 ☐ Inpatie 28a. Date of Injur (Month, Dey	y 28b. Time of	28c. Injur	4 Nursing Home	5 Residence Describe how in)
Division		Certification:	4 ☐ Homicide building, efc				City or Town, Ste		
	To the Hospital within 24 hours To the Funeral completely filled	Medical	29a. Certifler (Check only one) 1 Critfying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	examination end/or inve		pinion, death occurred a	t the time, date a		the cause(s)
	Z × C		29b. Signature and title of certifier Gaw, mo		Doos	59855	50	/	
			30. Name end address of person who completed cause of de Dinghin Guo, 560/	Lock Rav		id, Ball	himora	2 MD	, 2005 2/239
	Stat Registra	e	31. Date filed (Month, Day, Year) 32. Registre	er's Signeture	F. 1				

DHMH 16 Rev 6/95

RJ 05-00210 Virginia Physicia /Medic Examin **Funeral Director** permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ir e Modical Examination and once. Baltimore, Maryland 21215-0036

> Pnysician /Medical **Examiner**

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible

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Э.	Elizabeth	Gaylor	rd S	State of	Marylai				lealth ar	nd Me	ental Hy	gien	е			
	1 - State Registrar					Ce	ertitio	cate of	Death			Reg. N	20		0131	1.0
	1. Decedent's Name	e (First, Middl	e, Last)								Date of Dea Month	ath Da	ay	Year	3. Time of De	eath
ın al	VIRGINI	A	ELIZA	ABETH	GAY	LORD					Januar	_		05	05:40	A.M
er	4a. Facility Name (In	f not institution	n, give stre	et and num	ber)		4b.	City, Town,	or Location of	Death		40	. County	of Death	1	
	Johns Hop		Hospi					Baltin								
	5. Social Security N		6. Sex	20X F	7. Age (In yrs			Inder 1 Year oths Days	tf Under 24	Hrs.	8. Date of Birt (Month Da 1-13-	h y, <i>Xear</i>,	2	9. Birth	nplace (State or F	-oreign
	220-76-6			- Lugi	46	Yrs.					1-13-	195	5		MD	
	Usual Residence of 10a. State	10b. County	,		10c. C	ity, Town or L	Location	1							10d. tnside City I	Limits
ō	MD					BALTI	MOR	F.							1 X Yes 2	
ect	10e. Street and Nur	nher				DILLI		f. Zip Code				10a C	itizon of l	What Cor	untar?	
ä		BELNOR	D AVE	NUE		•	.		1224				SA	WIIIAL CO	unity:	
Be Completed by Funeral Director	11. Marital Status				dent Ever in U	18 13	Was F	Donadont of	Hispanic Origin	n2 (Sp.co	ify Vos or No		14 Pag	no - Amor	rican Indian,	
Ē	1 X Never Marri	ed 2⊡ Mar		Armed For	ces?	,	If Yes	, specify Cub	an, Mexican,	Puerto R	ican, etc.)			ck, White		
β	3 ☐ Widowed			tf Yes, Give			1 🗆 Y	es 2∭X No	Specify:				Specif	у: р т	ACK	
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plet		ify only highe	st grade c		4-45-1	(Giv	e kind o	of work done OT use retire	during most o	of working	g				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
E	Elementary/Secon	ndary (0-12)		Cotlege (1-	40r 5+)		ASHI					R	ETAI	Т.		
C	17. Father's Name (First, Middle,	Last)						18. Mother's	s Name	(First, Middle,					
To B	JERRY GA	YLORD							BESS	SIE J	JEAN PE	ATO	N			
_	19a. Informant's Na	me/Relations	hip (Type,	Print)		19b. Mai	ling Ad	dress (Stree	and Number	or Rural	Route Numbe	r, City	or Town,	State, Z	ip Code)	
	NANCY MC	CORMIC	K/FRI	END		2	2557	STEE	LE ROAD	, BA	ALTIMOR	E,	MD 2	1209		
	20a. Method of Disp					Place of Disp cemetery, cri	oosition	(Name of	log l	Da	ite	20c. L	ocation -	City or 1	Town, State	
	1 t√ Burial 2 [`4 ☐ Donation			oval from S	late	T ZION			ŀ	1-21	-05	RΛ	тттм	(ODF	MARYLAN	MD
	21. Signature of Fu								_						NS F.H.,	
	1 /a	mas	1.	MIN	100				AURENS						LAND 212	
	23a. Part . Enter th	ne disease, or	complicat	tions that ca	used the dea	th. Do not e	nter the	mode of dyi	ng, such as ca	ardiac or	respiratory ar	rest,			Approximate	
	shock, or hear Immediate Cause (Final	only one	cause on ea	ch line.	1. (Interval Between Onset and Dea	en ath
	disease or condition resulting in death)	n	a	On C	or as a conse	CILC	hol	ism						-		-
				0 0 0 0	1 43 4 001136	querice orj.										
ē	Sequentially list con if any, leading to im	nditions, imediate	b	Due to (d	r as a conse	quence of):										_
Examine	cause. Enter Unde Cause (Disease or that initiated events	nijury	6 .													
Exa	resulting in death) L	ast	U	Due to (c	r as a conse	quence of):										
cal			d													
ed	1		-						- 1							
Z.	IF FEMALE: 23b. Was decedent		23c.		ome of pregn th 2 🔲 Fet		□E⇔o	oic pregnanc	.,				23d. Da	te of deliv	very	
Sici	in the past 12 1Yes 2 [nt at time of			or (specify) _					Мо	onth	Day Yea	ar
žhž	9 Unknown															
Completed by Physiclan/Medl	Part It. Other signifi	icant conditi	ons contrib	outing to dea	ath but not re	sulting in the	underly	ing cause gr	ven in Part I.		23e. Did to				the cause of deat	
ted										_	1 O Y	es 2	No	3 Pro	bably 4 Unk	nown
ple											24a. Was autop		24b.	Were aut	opsy findings ava	allable
NO.											perfor	med? 2□ No	(death?	2□ No	
Be (25. Was case referr	red to medica							26. Place o	f Death (Check only o					
2	1 Tyes 2	No	Hos	pital: 1 □ In	patient 2] ER/Outpatie	ent 3[DOA Ot	ner: 4 🗆 Nurs	ing Hom	e 5 🗌 Resid	ence	6 Oth	er (Speci	ify)	
ü	27. Manner of Death	n 5 🗌 Pendir	10	28a. Date of (Month)	Injury Day Year)	28b. Time Injury		28c. Inju Wo	ry at rk?	28	d. Describe h	ow inju	ıry occuri	red		
atle	2 Accident	investi	gation				М	1 🗆	Yes 2 No)						
Ţ	3 ☐ Suicide 4 ☐ Homicide	6 Could determ		28e. Place o buildin	of tniury - At h g, etc. (Speci	iome, farm, s	treet, fa	ictory, office		28	If. Location (S City or Tow			er or Rui	ral Route Number	г,
Ce										lil.						
edical Certification:	29a. Certifier (Check only	1 ☐ Certifyir 2 ☐ Medical	ng Physici Examiner	: On the bas	sis of examin	owledge, dea ation and/or i	th occu	rred at the ti ation, in my	me, date and popinion, death	place, an	nd due to the o	ause(s date an) and ma d place.	anner as :	stated. to the cause(s)	
Med	01107			and manne	er stated.			29c. Licens							Day, Year)	
_	29b. Signature and	and or calling		4-	Qnn	4										
	Tal	ul	in	-	roll	el .	2	00	CME			Jan	uary	9,	2005	
	30. Name and addre			1 4 4												

State Registrar

31. Date filed (Month, Day, Year)

JAN 2 1 2005

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#2, perMD,GB39,1/27/05 TT

			For State Registrar	State of	Marylan	-	irtment of H tificate of I			giene (05	0	350
	Physici	an	1. Decedent's Name (First, Middle, I	•	, ,	_			2. Date of Dea Month	th $\frac{1}{\text{Day}}$	5/2005 Year	3. Tim	ne of Death
	/Medic	al	4. E-17. No 16 15. 15. 15. 15. 15. 15. 15. 15. 15. 15.		Carlma	P.		nger	1 1		2005	2:	40p. M
	Examin	er	4a. Facility Name (If not institution, g 410 N. Hilton		oer)		Balto	Location of Death		N/	nty of Death A		
	Funeral		5. Social Security Number 6. 219-72-6628	Sex 7.	Age (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	h /, Year)		lace (State)	ate or Foreign
_	Director		Usual Residence of Decedent			115.			5-14	-1959		Md	
	yland yland		10a. State 10b. County		10c. City	y, Town or Lo	cation				11	0d. Insid	le City Limits
	Ba-fel	ctor	Md	N/A	Ba1	to						1 X	Yes 2 No
	with th	Director	10e. Street and Number 410 N. Hilton	Street			10f. Zip Code 21229			10g. Citizen o		try?	
	ns 23	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.	S. 13. V	Vas Decedent of Hi	ispanic Origin? (Sp	pecify Yes or No-		A. ace - Americ	an India	n,
36	n 72 hours after death with the Maryland "natural", or items 23a or 28a-1 ehow saloal Esaninat be notified at	y Fur	1 Never Married 2 Married	If Yes, Give	∆ No	ļ. Ir	fYes, specify Cuba □ Yes 2🛣 No	n, Mexican, Puerto Specify:	Pican, etc.)	Spec	lack, White, e		
8	tural',	ed by	3 ☐ Widowed 4 Divorced 15. Decedent's	Year or Date	es:	16a Decer	lent's Usual Occupa	ation			Business/inc		
7.	C 2 0	plet	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4	lor E i	(Give	kind of work done of NOT use retired	during most of worl	king		nes Ho		a1
212		Completed	12th grade		N/A	Un	it Secret						
Maryland 21215-0036	d to o	Be	17. Father's Name (First, Middle, La Franklin Goodson	st)				18. Mother's Nam	e (First, Middle, Franks	Maiden Sum	ame)		
ız	2 should be a and Mental I is marked o aumatic ave	은	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street a			r, City or Tow	n, State, Zip	Code)	
	s 1 and 2 should f Health and Men item 27 is marke other traumatic		Franklin Goods	on - Fath			N. Hilto			o. Md 2	21229		
ore	t of He If item or oth		20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3	☐Removal from St	ate C	emetery, cren	sition (Name of natory or other plac	θ)	Date	20c. Location	n - City or To	wn, Stat	9
Baltimore,	permit. Pages to Department of Himportant: If ite any injury or ot once.		' 4 ☐ Donation 5 ☐ Other (Special Service Lice)	cify)	Ki		orial Par .Name and Addres	1	2005	Randa]	llstown	n, M	d
Ba	Depart Depart Impo		1 Signature of Full Street	EK (Imes) "		00 Waba	arch F/F sh Aveni	H West ie Balt	o, Md	212	15
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cally one cause on each	ed the death	n. Do not ente	er the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approx	Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a		VAL	ey C	ANCE	FR		4	1/2	and Death
	/Medical Examiner		Tooding in doding	Due to (or	r as a consequ	uence of):							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consequ	uence of):							
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (e.									
8760,	cate be executed physician and the burial-transit	al E	Comming an occur, and	Due to (or	ras a consequ	dence or):							
687		edical		d									
Вох	eath certifi attending I for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregna h 2 □Fetal		Ectopic pregnancy				ate of delive	-	W
.O.	The law requires that the death certifi tte has been signed by the attending tage 2 should be detached for use a	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnar 9□Unknow	nt at time of de n		Other (specify)			r	/onth	Day	Year
Ω.	that the part of t	by Ph	Part II. Other significant conditions	contributing to dea	th but not resu	ulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use co	ntribute to th	e cause	of death?
rds	w requires been sign should be								1 □ Y	es 2 No	3 Proba	ably 4	□Unknown
Records,	has be	Completed							24a. Was a	sy	. Were autop		
a H										2 No	death?	2□ No	
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	patient 2 🗆	ER/Outpatien	t 3 DOA Othe	26. Place of Dear er: 4 ☐ Nursing Ho	6.0	ne) ence 6 □0	ther (Specific	d	
J of		-	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of		28b. Time of Injury	28c. Injury Work		28d. Describe h				
sion	Attending r death. sctor: After by the fune	catlc	2 Accident investigat 3 Suicide 6 Could not	ion he			M 1 🗆 '	Yes 2 □ No					
Division	i Diff of	Certification:	4 Homicide determine	d 28e. Place o	f Injury - At ho p, etc. <i>(Specif</i>)	ome, farm, stre	eet, factory, office		28f. Location (S City or Tow		nber or Rural	Route I	Vum <i>ber,</i>
	Hospite 4 hours Funeral ely fille		(Check only 2 Medical Ex	Physician: To the baseminer: On the base									se(s)
	To the Hos within 24 ho To the Fun completely	Medical	one) 296. Signature and title of certifier	and manne			29c. License			29d. Date sign			
	F 3 F 8	7	> Yew Co	Luy.	MD		D 11.	354		1/20	0/2	00	5
1	-		30. Name and address of person wh	o completed cause	of death (Item	23a) (Type,	Print)	- / 2 -	- 0 -	1	1-		- 0
Y	7		E, W. COLE	ST /	GNE	-5 9	00 CAT	ON AVE	BALI	1. M	D L	12	29
	Sta Registi	-	31. Date filed (Morth Day, Year)	05	Jistiai's Sign	Los	de						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day Month Year **Physician** GRAY LISA JUNUCLY 1/ 2005 tion of Death 4c. County of Deeth 8.45PH 2005 /Medical 4e Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death Examiner CATONSVILLE COMMONS CATUNSVIlle BALTIMORE GENESIS If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. lest birthdey) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗓 F Director 08/11/1972 216-88-4182 Maryland Usuel Residence of Decedent e filed within 72 hours efter death with the Maryland il Hygiana. other than "naturel", or items 23s or 28s-1 show 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1K Yes 2 □ No Funeral Directo Maryland Baltimore 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code 1081 Ellicott Drive Way 21216 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Housekeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Pegas 1 end 2 should be filk mant of Health end Mantal Hy ant: If Item 27 Is merked oth Be Reginald Hunt Eartha Gray 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 1081 Ellicott Drive Way, Baltimore, Maryland 21216 Eartha Gray / Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/20/05 Baltimore, Maryland Metro Crematory Inc. 22. Name and Address of Fecility

The Derrick C. Jones F/H, P.A. 21. Signature of Funeral Service Licensee 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complication what caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner burial-trensit or Attending Physician: The law requires that the death cartificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ② Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Be Completed 1 Yes 242No 1 ☐ Yes 2 Ø No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4N Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To To the Hospital or Attending Physi within 24 hours after death.

To the Funerel Director: After this completaly filled in by the funerel dir this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier of death (Item 23e) (Type, Print) Ravan Blud 303 Baltimore MD 21239 2601 102HO4 -OCK gay 2 strer's Signature 31. Date filed (MT) State 2005 & grade Registrar

			State of Maryland / Dep 1- State Amend Item 25 per Verb., G839,0	artment of Healt 121 705 dbb Hillicate of Dea	th and Me ath	ental Hygie	ene j. No. 2005	01352
	Physici	an	1. Decedent's Name (First, Middle, Last) Lawrence Robert Gibson		2. Date of Death Month January	Day 11, 2005	3. Time of Death 4- 9:36 a M	
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Locat		January	4c. County of Death	9:30 a ···
	_xaiiiii		Northwest Hospital Center	Randallst			Baltimore	
	Funeral Director		5. Social Security Number 075-40-9629 6. Sex 1 M 2 F 57 Yrs.) If Under 1 Year If Ur Months Days Hou	urs Min.	B. Date of Birth (Month, Day, Y July 24,	(ear) 9. Birthp Cour New	lace (State or Foreign try) York
	/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			1	Od. Inside City Limits
	e Man	ctor	New Jersey Union Westfie	1d				12 Yes 2 □ No
	death with the Maryland ms 23a or 28a-f show	Directo	10e. Street and Number 770 Knollwood Terrace	10f. Zip Code		"	. Citizen of What Cour	•
	ns 23e	Funerai	11 Marital Status 12 Was Decedent Ever in U.S. 13	07090 Was Decedent of Hispania	c Origin? (Spec		nited Stat	
	i within 72 hours after death with the Marylan liene r than "naturel", or Items 23a or 28a-1 show Its Madical Examinet mat be notified at	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic If Yes, specify Cuban, Men 1 ☐ Yes 2 No Specify Cuban		ican, etc.)	Black, White,	
215-0036	thin 72 ho e. an "natur Mouted	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during DO NOT use retired)	most of working	g 16	ib. Kind of Business/In	dustry
V	e filed within II Hygiene. other than "	To Be Con	6+ Oral 17. Father's Name (First, Middle, Last)	Surgeon	Asthor's Name	(First, Middle, Ma	Dentistry	
laryian	e d la la la la la la la la la la la la la		Lewis H. Gibson	La	aFern	L. Leep	er	
	S s s			ing Address <i>(Street and Nu</i> Knollwood Tei				
e,	es 1 and of Health Item 27 rother tr		20a. Method of Disposition 20b. Place of Disposition	osition (Name of ematory or other place)	Da	ite 20	c. Location - City or To	wn, State
Baltimore,	Pages Iment of tent: If It jury or o			e Cemetery	01/15		cotch Plai	
ра	permit. Departr Import			2. Name and Address of F 728 Liberty I				
	Physician		23a. Part. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition				Seast.	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of): Sequentially list conditions.		0 V N > C	/1 P) (C E	21) 211315	
	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):					
98/60	ate hy:	dicat						
C. Box	The law requires that the death certific te has been signed by the attending page 2 should be detached for use as:	Physician/Me		□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ry Day Year
ds, P	uires that n signed b	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in P	Part I.		cco use contribute to the	e cause of death?
Kecords	sicien: The law require certificate has been si irector, page 2 should b	Completed				24a. Was an autopsy	d? prior to cor	psy findings available inpletion of cause of
Vital		O	25. Was case referred to medical	26. P	Place of Death	1 Yes 2 (Check only one)	No 1 ☐ Yes	2 N o
01 \	Physicien: this certific al director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 Fr/Outpatie		☐ Nursing Hom	e 5 Residenc	ce 6 ☐Other (Specify)
	ding Ph h. After th funeral	tion:	27. Manney of Death 1. Activate 5 Pending (Month, Day Year) 2 Activate investigation 2 Activate 1	of 28c. Injury at Work? M 1 Yes		3d. Describe how	injury occurred	
DIVISION	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)			3f. Location (Stree City or Town, S	et and Number or Aura State)	Route Number,
	e Hospite 24 hours e Funerel etely filled	ledical C	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, dea 2 Medicel Exeminer: On the basis of examination and/or and manner stated.					
	To the within 2 To the complet	Med	29b. Signature and title of certifier	29c. License numb			. Date signed (Month,	
			C. Ole 000 amson Chi	D/110	71	Ja	runky//1	2005
	20		30. Name and address of person who completed cause of death (trem 23a); (Type	Print)	611.	0-	mary/na	
	⊬ Sta Registr		31. Date filling Ren 2 Day 750 5 32. Registrar's Signature	IN KAND F	-LHI CO	119	MARYLAN	02/042

JANUARY 18, 2005 1:10 p.m.

Physician

/Medical

Examiner

Directo

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Completed

Be

Funeral

Director

with the Maryland

death v

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Pages 1

Department of Health and Mental Hygiene innertari, or Itams 23e or 28e-f show important: if Item 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic event, if a Medical Example in the Indilical at any injury or other traumatic event, if a Medical Example is not interest. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) of Vital Records, P.O. Box 68760 Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No ğ 4☐Pregnant at time of death detached 9 Unknown þ GLASS. EDWARD þ page 2 should be Completed After this certificate has been To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be examiner? 1 Inpatient 1 ☐ Yes 2 🙀 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 2 Accident Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 🗀 Suicide 4 Homicide Medical (Check only 29b. Signature and title of certifier 10

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year January 18, 2005 1:10 pm Joseph Glass 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dulaney Valley
If Under 1 Year If Under 24 Hrs. Stella Maris Hospice Center Baltimore .Sex 1M 2□F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours Yrs 92 213-07-2927 March 28, 1912 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. 2348 Martin Drive 21221 S. Α. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ X o If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Bethlehem Steel Crane Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel Glass Elizabeth Lewandowski 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Nueslein (Daughter) 430 Haslett Road Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Saint Stanislaus Cemetery 2005 Baltimore, Maryland Bruzdziński Funeral Home PA 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CEREBROVASCULAR ACCIDENT 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 Yes 1 ☐ Yes 2**X** No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 3□ DOA 2 ER/Outpatient 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 🛮 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 105 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 3:30PM Richard Arlen Garnett II 2005 Januare /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Burnie ANNE ARUNDEL GLEN NORTH ARUNDEL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 7,1979 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1**X** M 2□ F Hours 214 23 0162 Director Sept. Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "netural", or items 23e or 28e-f show traumatic event, the Medical Examiner must be inclifted at 1 Yes 21 No Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 401 Delaware Avenue 21060 U.S. Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. I □Yes 2 ☑ No f Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Road Crew Operator Construction 10th permit. Pages 1 and 2 should be file Department of Heath and Mental Hy Important: If item 27 1s marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Arlen Garnett Patricia Lee Brown 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1118 Linden Avenue Carrie Lotsey sister Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Bayview Crematory 1/13/2005 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 nonucult 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CEREBRAL /Medical Due to (or as a consequence of): Examiner. Sequentially list conditions, fam. leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examiner The law requires that the death certificate be execut Due to (or as a consequence of): Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a Division of Vital Records, P.O. 9 Unknown 9 Hinknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2□ No 2 No 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide

or Attending Physician: hours affer death. Ineral Director: After this y filled in by the funeral d within 24 hours a

> State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifie

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

2 1 2

ORIGINAL

Grande

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TSION BLOWNING NORTH ARUNDEL HOSPITAL DRIVE 32. Registrar's Signature

Bar San

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

			1 - State Registrar	ate of Maryland /		artmen tificate				Re	g. No.	005	01355
	Physici /Medio			garet T. Gunr	i n g				Jar	ate of Death fonth luary	Day 12	2005	3. Time of Death 7:55 P. M
	Examin	ier		lame (If not institution, give street and number) apeake Hospice House surity Number 6. Sex 7. Age (In yrs. last birthday)				4b. City, Town, or Location of Death Linthicum If Under 1 Year If Under 24 Hrs. 8. Date of Birth			Anne Arundel		
	Funeral Director		213 32 7382 1 M 2 Usual Residence of Decedent		Yrs.	Months	Days	Hours	Min. Ju	ate of Birth Month, Day, INE 21	, 1935	Mary	lace (State or Foreign try) /land
Maryla	the Maryland 28e-f show	rector	10a. State 10b. County Maryland Anne Arunde 10e. Street and Number	10c. City, To	wn or Lo		Code			10	g. Citizen	of What Cour	0d. Inside City Limits 1 ☐ Yes 2X No
	permit. Pages 1 and 2 should be lited within 72 hours after death with the Marylan Department of Heath and Mental Hydiene. Department of Heath and Mental Hydiene. Important: If time X7 Is marked other than "natural; or Itams 23a or 28e-f show any injury or other traumatic event, the Maryland Exemplant man be natified at once.	by Funeral Director	1 Never Married 2 Married 1	fas Decedent Ever in U.S. mred Forces? ☐ Yes 2 M No Yes, Give / ear or Dates:			2109 ent of Hi		gin? (Specify) , Puerto Ricar	Yes or No- n, etc.)	14.	Race - Americ Black, White, ecity: WH	etc.
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	should be file nd Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last) Robert G. 19a. Informant's Name/Relationship (Type, P		2h Mailir	og Address	/Street a			Louis	∍ Whi		Code
	Pages 1 and 2 s nent of Health an int: If item 27 Is i iry or othar trau		Edward Gunning Jr 20a. Method of Disposition 1 ABurial 2 Cremation 3 Remov	SON 20b. Place	6217 of Dispo	Orch	ard ne of ther place	Road	Lint Date	hicum 2	, Mar	yland on - City or To	21090 wn, State
Baltimore,	permit. Pa Departmen Important: any injury		*4 □Donation 5 □Other (Specify) 21. Signature of Funeral Service Licensee	Glen	22	. Name an	d Addres	s of Facility	Gonce	Fune	ral S	Service	Maryland, P.A.
1,092	ate be executed which is the burial-transit transit tr	ical Examiner	23a. Fart1. Enter the disease, or complication shock, or heart failure. List only one can immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a consequence to (or as a consequence).	e of):	115	50	DIST	HSE			1	Approximate Interval Between Onset and Death I—2 YRS
	The law requires that the death certilica ate has been signed by the attending ph page 2 should be detached for use as it	Physician/Med	in the past 12 months?	yes, outcome of pregnancy Live birth 2 Fetel dea Pregnant at time of death		Ectopic pr					23d.	Date of delive Month	ry Day Year
	w requires that been signed by should be deta	b	Part II. Other significant conditions contribu	ting to death but not resulting			ause give	en in Part I.			acco use o		e cause of death?
of Vita		Completed								24a. Whas an autopsy perform		prior to cor death?	osy findings available npletion of cause of
	To the Hospitel or Attanding Physician: Th within 24 hours after death. To the Funaral Director: After this certilicate completely tilled in by the funeral director, pag	ition: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospil 27. Manner of Death 1 Autural 5 Pending 2 Accident investigation	1 Inpatient 2 EHV	Outpatier Time of Injury		8c. Injury Work	er: 4 □ Nur	28d. l		nce 6 C		HOSPICE
Division	i i i i	Certification;	2 Could not be	e. Place of Injury - At home, building, etc. (Specify)	farm, str	eet, factory	, office			ocation (Str City or Town,		umber or Rura	l Route Number,
	To the Hospitel or within 24 hours after To the Funaral Director completely tilled in I	edicai	(Check only 2 Medical Examiner: (one)	n: To the best of my knowled On the basis of examination and manner stated.	lge, deatl and/or in	vestigation	in my op	pinion, deat	d place, and d h occurred at	the time, da	e and pla	ce, and due to	the cause(s)
	with To 1	2	29b. Signature and title of certifier Court of the court of the certifier	as.		1	129	number			1/13	gned (Month,	
	St. Regist	ate rar	30. Name and address of person who comple CARLOS 3, 2 (6 F) M. 31. Date filed (Month, Day, Year)				, cm	AIN I	404	GIEN	BUR	ENIE W	us 21061

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 Year J Month **Physician** RAY GREENBERG 9 19:18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Univ. of Maryland Medical Syst Baltimore N/A tf Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth AUG. 27, 1921 Birthplace (State or Foreign Country) **Funeral** 6. Sex Min. 1 □ M 2 🛱 F Months Days Hours NY 83 095-14-8989 Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or itams 23e or 28e-f ehow treumstic event, it a Madical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 USA 7202 ROCKLAND HILLS DRIVE #201 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiane. Importent: if item 27 is marked other then "naturel", or item any injury or other treumatic event, if a Medical Energiese 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed by 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Etementary/Secondary (0-12) Coltege (1-4or 5+) TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SHUSTER GOLDBERG MARY ABRAHAM 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 BATESON DRIVE - ANDOVER, MA 01810 SANFORD GREENBERG / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) (ANSHE EMUNAH)AITZ CHAIM 1/11/2005 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat Multiple Injuries **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): physician the burial Box 68760. Physician/Medical tF FEMALE 23c. tf yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. I the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by the should be detached detach Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 Yes 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) XXYes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After thi 28a. Date of Injury 28c. Injury at Work? 28d Describe how injury occurred Subject was a passenger in 27. Manner of Death 28b. Time of Certification: 1 / 990 5 ay Year) Injury 1 Natural
2 X Accident 5 Pending 3:59 1 ☐ Yes 2X No death. investigation Car which collided w/jeep

28f. Location (Street and Number or Rural Route Number,

Green "Summit t & Hurdle Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funerel Dire Street Ford Ct Greenspring, Md 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D51654 Jan 19, 2005 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Scalea, MD 22 S. Greene St. Baltimore, Md 21201 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JAN 2 1 2005 Registrar

Donte Hopkins 05-00351 RPD

			State of Maryland / Dep	artment of Health and Mental ertificate of Death	Hygiene 005 01357
	a .		Decedent's Name (First, Middle, Last)	2. Date of	
	Physici /Medic		Dente Hopkins		ary 14°, 200°5° 0951 Рм
	Examin	er	4a. Facility Name (If not institution, give street and number) Johns Hopkins Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 219 08 1.746 120 Yrs.	Months Days Hours Min(Monti	of Birth h, Day, Year) 9. Birthplace (State or Foreign Country) MEZ 26, 1914 M.D
	and w	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
	with the Marylan or 28a-f show be notified at	ğ	M.D N/a BAItimo	N.S.	1. Tes 2 □ No
	r 28a-f	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	23a or	aj D	500 N. Robinson St.	21205	115.4
	ems ems	Funeral		Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.	or No- Black, White, etc.
36	within 72 hours after death with the Maryland ene. than "netural", or tems 23e or 28e-f show the Madeal Examinet must be maillist at he Madeal Examinet must be maillist at	by Fu	1 Never Married 2 Married 1 Yes 2 No	1 ☐ Yes 2 No Specify:	Specify: Black
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Mar	es 1 and 2 should b of Health and Ment: I item 27 is marked r other traumatic e			ing Address (Street and Number or Rural Route N	
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IOL	ages ant of at: If it		1 Payriot 2 Comption 2 Removal from State Certificary, Cre	anatory or other place)	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other <u>once</u> .		21. Signature of Funeral Service Licensee	1 CEME teny 1/23/05 22. Name and Addr s of Facility BE+15 F	unean Home
Ä	Dep Imp any		Yatnora Botto	1129 N. CAROLINE St &	BALFIMORE, MD 21213
			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.	The state of the s	Interval Between
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H H		performed? death? (es 2 No 1 No 1 No			
Vita	Attending Physician: The death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check of Other)	
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on	th. : After s funer	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 1 1 4 0 5	of 28c. Injury at Work? 1 Yes 2 No 5	ubuctshot
Visi	al or Attendi s after death. if Director: A id in by the fu	ifice	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. Locat	ion (S reet and Number or Rural Route Number, or Town, State)
Ö	tal or	Certification:	Street	N.	Curley St. Baltimere MD
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only 2 Medicel Exeminer: On the basis of examination and/or in	th occurred at the time, date and place, and due to	the cause(s) and manner as stated.
	thin 2 the the	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	F 3 5 8		Margar Hallan Ind	O.C.M.E.	January 15, 2005
Į.			30. Name and address of person who completed cause of death (Item 23a) (Type	o, Print)	
1	ע		CAROL HALLAN Med 111 Pe	nn Street, Baltimore, M	Maryland 21201
1	Sta		31. Date filed (Month, Pay, Year) 32. Figistrar's Signature	1 · · · ·	
	Regist	ar	JAN 2 1 2005 Strew &		

RJState of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year **Physician** HARding 13 2005 4c. County of Death 12:35 P.M. /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore in Under 24 Hrs. Hours Min. 2651 Kennedy Avenue, 2nd Floor 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months M.D. 1**X** M 2□ F 5 Yrs. 9847 Director 219 60 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heatith and Mental Hygiene. ant of Heatith and Mental Hygiene ant: If item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, I'te Medical Examinat must be notified at 1/ Yes 2 □ No Director BA HIMER E MID 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2651 21218 U.S. A Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) odd JoBS Odd Jurs 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) To Be HARding ATHEN RICKS Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Britimure, MD 21213 Kuth JERDNER Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages I Department of F Important: If ite any injury or ot ange. 1 Burial 2 Cremation 3 Removal from State M.f. Cannel BALLIMORE MAP 1/20/05 22. Name and Address of Facility BEHS Funeral Horne 21. Signature of Funeral Service Licensee BAITIMURE MD 21213 1129 N. CARSINE 57 Jatuara Betts 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) athorosclerotic Pnysician and iovascular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off-Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Tes 2 No 3 Probably 4 Vinknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 XYes 2 □ No 4 Nursing Home 5 Residence 6 DOther (Specify) At scene 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this funeral 27. Manner of Death 1 A Natural 2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif January 14, 2005 OCME. 30. Na who completed cause of death (Item 23a) (Type, Print) ne and address of person MOLLAK M11 Penn Street, Baltimore, Maryland 21201 MONICA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

ORIGINAL

DHMH 17 Rev 1/2001

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last) Darrell H. Hawkins 4a. Facility Name (If not institution, give street and number) 2411 Braddock Road Funeral Director 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Jan. 4b. City, Town, or Location of Death Mt. Airy 5. Social Security Number 218-72-4269 1. Decedent's Name (First, Middle, Last) 4b. City, Town, or Location of Death Mt. Airy 4b. City, Town, or Location of Death Mt. Airy 4c. Month Days Hours Min. (Month, Days Aug. 22) 45 Yrs.	Th Day Year 18 2005 2:48 P.
/Medical Examiner 4a. Facility Name (If not institution, give street and number) 2411 Braddock Road 4b. City, Town, or Location of Death Mt. Airy 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. (Month, Days)	18 2005 2:48 P.
2411 Braddock Road Mt. Airy 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min. (Month, Day. Months Days Hours Min. (Month, Day.)	4c. County of Death
Funeral Months Days Hours Min, (Month, Day	Carroll
219 72 /260 IMM 2UF //5 Vrs Month of July 219	9. Birthplace (State or Fore
Director 218-72-4269 45 Yrs. Aug. 22	, 1959 Maryland
	10d. Inside City Lim
Maryland Carroll Mt. Airy	1 ☐ Yes 2 🙀
10f. Zip Code	0g. Citizen of What Country?
2411 Braddock Road 21771 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	United States 14. Race - American Indian,
11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	Black, White, etc.
To a. State 10b. County 10c. City, Town or Location Maryland Carroll Mt. Airy 10a. State 10b. County Mt. Airy 10a. State 10b. County Mt. Airy 10b. Street and Number 10f. Zip Code 11 2411 Braddock Road 21771 11. Marital Status 11. Marital Status 11. Marital Status 11. Never Married 2 Married 12. Was Decedent Ever in U.S. Almed Forces? 11. Yes 2 Married 11. Yes 2 Married 11. Never Married 2 Married 12. Was Decedent Ever in U.S. Almed Forces? 11. Yes 2 Married 11. Never Married 2 Married 12. Was Decedent Ever in U.S. Almed Forces? 11. Yes 2 Married 11. Never Married 2 Married 12. Was Decedent Ever in U.S. Almed Forces? 11. Yes 2 Married 11. Never Married 2 Married 12. Was Decedent Ever in U.S. Almed Forces? 11. Yes 2 Married 11. Never Married 2 Married 12. Was Decedent Ever in U.S. Almed Forces? 11. Yes 2 Married 12. Was Decedent Ever in U.S. Almed Forces? 11. Yes 2 Married 12. Was Decedent Ever in U.S. Almed Forces? 11. Yes 2 Married 12. Was Decedent Ever in U.S. Almed Forces? 11. Yes 2 Married 12. Was Decedent Ever in U.S. Almed Forces? 11. Yes 2 Married 12. Was Decedent Ever in U.S. Almed Forces? 12. Was Decedent Ever in U.S. Almed Forces? 12. Was Decedent Ever in U.S. Almed Forces? 12. Was Decedent Ever in U.S. Almed Forces? 12. Was Decedent Ever in U.S. Almed Forces? 12. Was Decedent Ever in U.S. Almed Forces? 12. Was	Specify: White
15. Decedent's Education (Specify only highest grade completed) (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Maryland Carroll Mt. Airy Maryland Carroll Mt. Airy	N.I.H.
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, I	Maiden Sumame)
Hartsel S. Hawkins Martha N. Hal	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Numbe	
20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition (Name of cemelery, crematory or other place)	20c. Location - City or Town, State
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1 □ Donation 5 □ Other (Specify) South Carroll Crematory 2005	Winfield, Maryland
21. Signafure of Funeral Service Licensee	ctors, PA
1212 w. Old Elberty Road w.	infield, MD 21784
23a art1. Inter the disease, or complications that the death. Do not enter the mode of dying, such as cardiac or respiratory arm shock or heart failure. List only one cause on a line. Immediate Cause (Final disease or condition resulting in death)	Interval Between Onset and Death
Examiner	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	
Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
o e d so cicion se de	
See the state of t	
25. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
O of the following and the fol	
s s s s	pacco use contribute to the cause of death? es 2. No 3 □ Probably 4 □ Unknown
24a. Was a autops perform	y prior to completion of cause of
25. Was case referred to medical examiner?	θ)
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Reside	ence 6 Other (Specify)
1 X Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	
1 Inpatient 2 EN/Outpatient 3 DA 4 Nursing Home 5 A Heside 27. Manner of Death 1 Notatural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 3 DA 4 Nursing Home 5 A Heside 28d. Describe how work? 1 Yes 2 No 28d. Describe how work? 28d. Describe how w	reet and Number or Rural Route Number, o, State)
1 Yes 2 No No No No No No No	ause(s) and manner as stated. ate and place, and due to the cause(s)
## 1 29b. Signature and title of certifier 29c. License number 29	9d. Date signed (Month, Day, Year)
tattech fullows 20806	1/20/2005
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATRICK TURNS in (WO LIBERTY RD ELDERS BURG) State Registrar	UD 21784
State 31. Date filed (Month, Day, Year) Registrar JAN 2 1 2005 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. NO 05 0 136	0
	Physici /Medio	cal	1. Decedent's Name (First, Middle, Last) STAN LEY 1- OUSMAN 2. Date of Death TANUAR Pay 20 2005 9:15	ith PM
	Examir	ner	4a. Facility Name (If not institution, give street and number) NORTHWEST HOSPITAL CENTER 4b. City, Town, or Location of Death RANDALLSTOWN BALTITOOR & 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fo.	
	Funeral Director		5. Social Security Number 192–22–2762 1 XI M 2 F 7. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Fo. Coulety) 1 Agy 1 Organization 1 Agy 1 Organization reign	
	Ba-f show	ctor	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lite Md. Baltimore Baltimore 1 □ Yes 2 □	
	th with th	ai Dìre	10e. Street and Number 405 K Mysty Wood Way 10f. Zip Code 21228 10g. Citizen of What Country? U.S.A.	
9036	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or frams 23e or 28e-f show event, The Madical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Adjust Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Was Decedent Ever in U.S. Adjust Forces? 16. Yes 2 No Specify: Specify: White	
1215-	c * 39		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	nen:
altimore, Maryland 21215-0036	should be filed withir nd Mental Hygiene. marked other than imatic event, II's M.	To Be Co	12 Salesman Environmental Elem 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Housman Estelle Bean	1611
Mary	nd 2 salth ar		19a. Informant's Name/Relationship (Type, Print) Anthony Nolan - Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3550 Shane Dr., Hampstead, Md. 21074	
more,	000-		20a. Method of Disposition Magnetic Magnetic Magnetic Date 20c. Location - City or Town, State	
Balti	permit. Pag Department important: I any injury o once.		21. Signature of Fureral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 21117 11605 Reisterstown Rd., Owings Mills, Md.	
8760, 7	Cate be executed /Medical Examiner sthe burial transit	edicai Examiner	23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
P.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and lage 2 should be detached for use as the burial-transit	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	
	quires that n signed b		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 DUNA	
al Reco			HYPERTENSION . 24a. Was an autopsy performed	ble of
Division of Vital Records,	tanding Physicath. tor: After this the funeral directions.	Certification: To Be	25. Was case referred to medical examiner? 1	
Divis		Certific	3 Suicide 4 Homicide Could not be determined See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State)	
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	le dical	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
)	To To	M	29b. Signature and tille of certifier PMYSICIAN 29c. License number 29d. Date signed (Month, Day, Year) TANVARY & DAGG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	6-
	را Sta	te.	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVVELA ITALLI ITALISH: 540 OLD COVITRO: MP 1/13 31. Date filed (Month, Day, Year) 32. Registrar's Signature	3
	Registr		JAN 2 1 2005 > Block 15 Species	

		-	For State State Registrar		artment of Health and Natificate of Death	Mental Hygier Reg. t	/11/5	01361
	Physici	an	Decedent's Name (First, Middle, Last) Nettie Cleo Hardy			2. Date of Death January	2005	3. Time of Death 7:00p M
	/Medic Examin		a. Facility Name (If not institution, give street and r Carroll View Assisted I		4b. City, Town, or Location of Death		4c. County of Death Carro11	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 🏋 F	7. Age (In yrs. last birthday) 88 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Feb 15 19	ar) Cou	place (State or Foreign ntry)
	Maryland f show		Jsual Residence of Decedent 10a. State 10b. County Carrol1	10c. City, Town or Le Hampstea				10d. Inside City Limits 1 ☐ Yes 2 🕍 No
	with the Name of 28e-	I Direct	10e. Street and Number 1915 Lang Road		10f. Zip Code 21074	10g. (USA	Citizen of What Cou	ntry?
336	mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland satment of Health and Mental Hygiene. sortent: If item 27 is marked other than "natural", or Items 23a or 28e-f show iorient: If item 27 is marked other than "natural", or Items 23a or 28e-f show iorient: If item 27 is marked other than "natural" or retified at injury or other traumatic event. The Medical Evantical must be notified at its injury or other traumatic event.	by Funeral Director	1 □ Never Married 2 □ Married 1 □ Ye.	Forces? s 2 🛣 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 \$\frac{\text{Y}}{2}\$ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	etc.
Maryland 21215-0036	i within 72 hou iene. r than "nature tha Medical E	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College 11	(Give	odent's Usual Occupation e kind of work done during most of wor DO NOT use retired) pational therapist	king	Kind of Business/Ir	
and?	ild be filed lenfal Hyg ked othe lic event.	To Be C	17. Father's Name <i>(First, Middle, Last)</i> William Rush Thomas			ne <i>(First, Middle, Maid</i> nn Brewer	en Sumame)	
Mary	nd 2 shou aith and M 27 is mai		19a. Informant's Name/Relationship (Type, Print) Janice Rensch (daughter		ing Address <i>(Street and Number or Ru</i> Lang Rd., Hampste		y or Town, State. Zi .074	o Code)
Baltimore,	permit. Pages 1 and Department of Heali Importent: If item 2 eny injury or other once.		20a. Method of Disposition 11℃ Burial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 □ Other (Specify)	m State	osition (Name of matory or other place) eld Cemetery 1-25-		Location · City or T	
Balti	permit. Departm Importe eny inju		21. Signature of Funeral Service Licensee / L		2. Name and Address of Facility Har .O. Box 195 Sykesy			Chape1
4	Physician		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of Immediate Cause (Final disease or condition		ster the mode of dying, such as cardiac SCUCV ACCIDE	or respiratory arrest,		Approximate Interval Between Onset and Death
,	/Medical Examiner bhysician and the burial-transif	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events c.	to (or as a consequence of): HUNG HONE C (or as a consequence of): to (or as a consequence of):	\$1.60			Sycons
.O. Box 68760,	death certifi e attending i d for use as	Physician/Medical	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	rery Day Year
ds, P	es De	by	Part II. Other significant conditions contributing to	o death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to 2 □ No 3 □ Pro	the cause of death? bably 4 @tinknown
Vital Record	The law afe has b page 2 sl	Completed				24a. Was an autopsy performed 1 Tyes 2 T	prior to co	opsy findings available ompletion of cause of
of	Physicien this certifiral director	To Be	27. Manner of Death 28a, Da	□ Inpatient 2 □ ER/Outpatie te of Injury 28b. Time Injury ent 3 DOA Other: 4 Nursing H	ath (Check only one) lome 5 Pesidence 28d. Describe how in		ify)	
Division	or Attending affer death. Director: After	Certification:	3 Suicide 6 Could not be	ace of Injury - At home, farm, s illding, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	and Number or Rui ate)	ral Route Number,
	To the Hospitel or within 24 hours at To the Funerel Di completely filled in	edical C	(Check only 2 Medical Examiner: On the		ath occurred at the time, date and place nvestigation, in my opinion, death occu			
)	To the within To the Comple	Me	29b. Signature and title of certifier Conclusion of the Control o		29c. License number 0 5 2 0 3 5		Date signed (Month	
	10		30. Name and address of person who completed c	ause of death (Item 23a) (Type	e. Print) West,	minister	Mp 2	21 2005
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 2 1 2005	Registrar's Signature	o de			

				epartment of Health and of Certificate of Death		2005	01362
	5 1		Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physic /Medi		Emma O. Harney		January	Day Year 18 2005	3:45 PM
	Exami		4a. Facility Name (If not institution, give street and number) St. Agnes Healthcare	4b. City, Town, or Location of Deat Caltimore	h	4c. County of Death	h
	Funeral Director		020 20 0002	day) If Under 1 Year th Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 6/197.1922	/	nplace (State or Foreign untry)
	and w		Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	the Marylan r 28e-f show	tor		licott City			1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cor	untry?
	death w	erai	3004 N. Ridge Rd. Apt.127	21043		USA	
920	or Ita	by Funeral	3 Mary Widowed 4 □ Divorced If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2 ★ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify:	
5-0	72 hours "netural", adical Ex-	eted	15. Decedent's Education 16a. [(Specify only highest grade completed)	Decedent's Usual Occupation	rking 16	b. Kind of Business/l	
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Aan	2 sho and I is ma		19a. Informant's Name/Relationship (Type, Print)	Mailing Address (Street and Number or Ru	ıral Route Number, C	City or Town, State, Zi	ip Code)
	s 1 and 2 should if Health and Men item 27 is marke other treumetic			B7 Hallowed Stream Disposition (Name of		City,Md.	
ē	Pages ent of nt: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	crematory or other place)	6-20	C43 1/1/2/2	5-00
Baltimore,	permit. Pages Department of I Importent: If ite any injury or or once.	i	21. Signature of Funeral Service Licensee	rematory 1/19 22. Name and Address of Facility Ha	/2005 Ca	tonsville ke's Fami	Md.
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	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death)	t enter the mode of dying, such as cardiac Law Accident	or respiratory arrest	,	Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence of	:			
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	:			
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8760,	icate be executed physicien and s the burial-transit	dicai E	Due to (or as a consequence of				
9	tificate ng phy as the	ledic	d.				
.O. Box	The law requires that the death certificate has been signed by the attending rage 2 should be detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliv Month	ery Day Year
Records, P	quires that in signed t uld be det	ed by P	Part II. Other significant conditions contributing to death but not resulting in the Obstaclive Sleep Aprilea	ne underlying cause given in Part I.	23e. Did tobac	co use contribute to t	. /
eco	faw requir as been si 2 should	piet	Chronic Obstructive Puln	ronary Disease	24a. Was an	24b. Were auto	opsy findings available
<u>~</u>		Com	Congestive Heart Failur	e O	autopsy performed 1 ☐ Yes 2 €	death?	mpletion of cause of 212 No
Vital	Physiclen: this certific ral director,	Be	25. Was case reterred to medical examiner?	Other	th (Check only one)		
of	Phy this	7: To	27. Manner of Death 28a. Date of Injury 28b. Tim		ome 5 Residence	e 6 ☐Other (Special	(y)
ion	Attending Ph er death. rector: After th by the funeral	atio	2 Accident investigation	ry Work? M 1 ☐ Yes 2 ☐ No		(-)	
Division of	or Attendentiacted	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rura tate)	al Route Number,
7	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29a. Certifier 1 Certifying Physician: To the best of my knowledge, o	eath occurred at the time, date and place.	and due to the cause	e(s) and manner as s	tated.
	the Ho hin 24 the Fu	Medical	one) and manner stated.	r investigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
	To wit		29b. Signature and title of certifier Null Gumber April 12	29c. License number 10em P18612		Date signed (Month,	
	\		30. Name and address of person who completed cause of death (ttem 23a) (Ty		Rall	binas M	D 26225
	Sta Registr		31. Date filed (Month Port, Year) 2005 32. Figure 32. Signature	U Sum Cuton Ave	nne, rant	imore, 111.	V, 21229.
	riegisti	AIT	FRIEND ST	Cine (5)			

HARNEY, EMMA.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Charles F. Holm January 15, 2005 12:02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Kris-Leigh Assisted Living Davidsonville Anne Arundel 6. Sex 1X M 2□ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Director 9-16-1924 102-18-2870 80 Michigan Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23a or 28a-f show the Medical Exeminer must be motified at 1 ☐ Yes 2X No Directo Maryland Anne Arundel Edgewater 10e. Streel and Number 10g. Citizen of What Country? 10f. Zip Code 1020 Old Turkey Point Rd. 21037 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 2 1 No If Yes, Give Year or Dates: 1944–65 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: ð 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ulth and Mental Hygiene. 27 ie marked other then 'r r traumatic event, I' a My Elementary/Secondary (0-12) College (1-4or 5+) Holm Yacht Sales years Owner/ Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ion C. Holm Ellen L. Harrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health attem 27 i 5 Seabright Way, Rehoboth Beach, DE 19971 Item 27 William H. Holm/ Son Baltimore, 20a. Method of Disposition
1 ☐ Buriel 22 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H
Important: If Ite
eny Injury or ot
once. 4 Donation 5 Other (Specify) 1-18-05 Kalas Crematory Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Licenses 2973 Solomons Island Rd. Edg.
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Consestive disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. the 9 Unknown 9 Unknown signed by d Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2□ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Stother (Specify) Assisted Hospital: 1 Inpatient Other: 4 Nursing Home 2 1 Tes 3□ DOA 2 ER/Outpatient 5 ☐ Residence 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: To the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Diractor: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29d. Dale signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 2003 MEDICAL 0 ANNAPOLIS. 32. Reg State Prive Registrar

			For State Registrar	State of Maryl		artment of H		, ,	2000	5 01361
		4,0	Registrar 1. Decedent's Name (First, Middle, Last)	1		tillicate of L	Jealii	2. Date of Deal	eg. No. UU.	3. Time of Death
	Physicia	an						Month	Day Ye	ear 10 15 M
0	/Medic		Allen L. Howdyshel			4h Cily Tourn or	Location of Death	January	4c. County of E	
	Examin	er	4a. Facility Name (If not institution, give			,				
		¥.	Alice Manor Nursin 5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year	Baltimore If Under 24 Hrs.	8. Date of Birth		Pre City
- AC	Funeral		11	ŠM 2□F 72		Months Days	Hours Min.	(Month, Day		Birthplace (State or Foreign Country)
	Director		223-38-4362 Usual Residence of Decedent	12	<u>.</u>			11/06/	1932 VA	
	land ow		10a. State 10b. County	10c.	. City, Town or Lo	ocation				10d. Inside City Limits
	Mary -f sh	tor	MD Baltimor	o City	Baltimore	_				1 ☐ Yes 2 💆 No
	the 28a	Director	10e. Street and Number	e city b	Jai CIMOL	10f. Zip Code		1	0g. Citizen of Wha	t Country?
	3g or		1420 Union Avenue	Amt C		21211			USA	
	ns 2;	era	1430 Union Avenue,	12. Was Decedent Ever i	in U.S. 13.	Was Decedent of Hi	spanic Origin? (Spe	cify Yes or No-	14. Race - /	American Indian,
10	fter of the contract of the co	Funeral	1 ☐ Never Married 2 🕅 Married	Armed Forces? 1 ☐ Yes 2 ▼No		If Yes, specify Cuba		Rican, etc.)	Black, \	White, etc.
036	urs a	by	3 Widowed 4 Divorced	If Yes, Give 22 Year or Dates:		1□Yes 2XX No	Specify:		Specify:	hite
0	within 72 hours after death with the Maryland iene. rthen "natural", or Items 23a or 28a-f show the Medical Exameration in the Me	Completed	15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usual Occupa	ation	na	16b. Kind of Busin	ess/Industry
218		ple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)		Resident	ial
21	e filed within al Hygiene. I other then vent, the we	No	6		Paint	er				
pu	be filed ntal Hygi d other event.	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, I	Maiden Sumame)	
<u> a</u>	uld b Ments irked	To	Thomas Howdyshell				Goldie L	eeanna U	nknown	
Maryland 21215-0036	s 1 and 2 should be if Health and Mental is tem 27 is marked oother treumatic eve		19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Street a	and Number or Rura	il Route Number	, City or Town, Sta	te, Zip Code)
	is 1 and 2 of Health a item 27 is other tree		Doris Howdyshell/W			Union Av		. C Bal	timore, 1	MD 21211
Baltimore,	m Q >-		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	20	b. Place of Dispo cemetery, cre-	sition (Name of matory or other plac	e)		20c. Location - City	y or Town, State
Ĕ	Pages nent of I ont: If its		1 ☐ Burial 2 Ki Cremation 3 ☐ P	Temoval IIOIII State		ke Cremat	· ·	Jan 21 2005	Beltsvill	e, Maryland
alti	그 문 변 등		21. Signature of Funeral Service Licens	ae.	COL 22	2. Name and Addres	s of Facility			
m	Departiment of the permit of t) Sefati	A Mpa		remation a 3717 Green				Maruland
			23a. Part1. Enter the disease, or compl	ications that caused the c						Approximate Interval Between
R	Pnysician		shock, or heart failure. List only or Immediate Cause (Final		Deri	pherel	1105	Chler	disease	Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a con	,	12401	1(13	CALLA	a 12542	
F	Examiner			,		19VA C	MA PY	21SE	2850	
		ē	if any, leading to immediate	b. Due to (or as a con						
	uted	i E	cause. Enter Underlying Cause (Disease or injury that initiated events		Chn	me as	38muct	nce Ph	mensini	disease
Ć,	The law requires that the death certificate be executed attents been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Examine	resulting in death) Last	Due to (or as a con						
8760,	e be rsicia e bur			d	1+4	perter	804			
.89	ificat g phy as the	Physician/Medical								
Вох	eath certific attending p	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		Te			23d. Date of	delivery
B	death a atte	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□I 4□Pregnant at time		⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>			Month	Day Year
0	at the de by the	hys	9 Unknown	9□ Unknown						
σ,	res thal igned to be det		Part II. Other significant conditions con	ntributing to death but not	t resulting in the u	inderlying cause give	en in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
ds	quire; n sig ald ba	p	Bi	let Abi	ave k	nee P	montet	ICh 10 Y	es 2□No 3□	Probably 4 Qunknown
Records,	w require been signatured should b	Completed by						24a. Was a	n 24b. Wer	e autopsy findings available
Re	he tav e has	m						autops	med? deat	
G		ပိ	25. Was case referred to medical				26. Place of Death		2/3 No 1 🗆	Yes 28 No
Vital	6 + 2		examiner?	Hamital.	_	Oth				-
	sici: cer irec	00		Hospital:	2 ER/Outpation	ot 2000A Othe	A Viureing Ho			Sponiful
of	ys dii	To B	1 ☐ Yes 2 X No	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpaties 28b. Time of	of 28c. Injury	at wursing Hol		ow injury occurred	Specify)
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			State of Maryland / Department of Health and 1 - For State Registrar Certificate of Death	Mental Hy	giene Reg. No.2	05	0 365
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Do	eath Day	Year	3. Time of Death
	/Medi	cai.	Charles H. Howerton 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deat	Januar	-	2005 ty of Death	0950 AM
	Examir	ner	University Specialty Hospital Baltimore		N/Z	-	
	Funeral Director		5. Social Security Number 6. Sex 230 32 4474 1X M 2 F 75 Yrs. Security Number 1 Year 1 Gunder 1 Year 1 Gunder 24 Hrs Months Days Hours Min.		ay, Year)	9. Birthpi Coun Viro	lace (State or Foreign try) Jinia
			Usual Residence of Decedent	TCD. 4	, 1525		
	death with the Maryland ms 23a or 28a-f ahow Innest be notified at	or.	10a. State 10b. County 10c. City, Town or Location Maryland N/A Baltimore			11	0d. Inside City Limits 1XX Yes 2 ☐ No
	the M	Director	10e. Street and Number 10f. Zip Code		10g. Citizen o	f What Coun	
	h with	Ö	111 South Popleton Street 21201		U.S		
5	ams 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S	Specify Yes or Note of Rican, etc.)	0- 14. Ra	ace - America	
ti	36 safte	by Fu	1 ☐ Never Married 2 ☐ Married 1 五 Yes 2 ☐ No If Yes, Give Year, of Dates: Korean 1 ☐ Yes 2 ▼ No Specify:	,	i	ity: Whi	
bwer	-00-		15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of	Business/Inc	lustry
5.	Phin 72	Completed	(Specify only highest grade completed) (Give kind of work done during most of wo life. DO NOT use retired) (Flementary/Secondary (0-12) (College (1-4or 5+)	rking			,
100	21 ed wit ygiene ygiene ygiene t, the	Соп	7th Handy Man				Rigging Co.
1	Maryland 21215-0036 d 2 should be filed within 72 hours after death with and Mental Hygiens 123 is marked other than "natural", or Itams 23a traumatic avent, the Medical Examinations 1	Be		me <i>(Fir</i> st, <i>Middl</i> e Known	e, Maiden Suma	ame)	
	ryle hould d Mer marks	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Richard N		per City or Tow	n State Zin	Code)
3	Ma nd 2 s lith an 17 ia r trau		Bertha Elliott / sister in law 1260 Glyndon Avenue				nd 21223
7	or Health of Hea		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location	- City or To	wn, State
20	altimore, mit. Pages 1 at partment of Hea portant: If item y injury or otha CR.		1 Aburial 2 Cremation 3 Bemoval from State	0/2005	Baltimo	ore, M	aryland
2)	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f ahov any joury or other traumatic avent, the Medical Examinations is indiffied at once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility G				, P.A. rland 21225
	₩		234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiar shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition a Curcinuma of the	lung			Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	7.0	/'		
	123 M 20	Į.	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. Due to (or as a consequence of): Puel or or as a consequence of): Autor Callon Autor Call	the ?	2014		
	Offed Basit	Examiner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. Prelmon any fuberculost	Ĵ			
	3760, ————————————————————————————————————		resulting in death) Last Due to (or as a consequence of):				
		Ilcal	d				
	cords, P.O. Box 68 w requires that the death certific been signed by the attending pl should be detached for use as t	Physiclan/Medical	IF FEMALE:				
	Box eath cert attending for use a	clan	23b. Was decedent pregnant in the past 12 months? 1			ate of delive Ionth	ry Day Year
	P.O. hat the de de by the detached	nysic	1 Yes 2 No 9 Unknown 9 Unknown				
	s that	by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use co	ntribute to th	e cause of death?
	ords			1 🗆	Yes 2□No	3 ☐ Proba	ably 4 Unknown
	0 8 8	Completed		24a. Was	psy	prior to con	osy findings available
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	Of Phys rr this aral di	. To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	dome 5 Res 28d. Describe	how injury occu)
	ion nding ath. r: Afte e func	atlor	Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No				
	IVIS	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		Street and Nun	ber or Rural	Route Number,
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	Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 20 Medical Examiner: On the bast of examination and/or investigation, in my opinion, death occur and manner stated.				
	o the vithin o the	Med	29b. Signature and title of certifier 29c. License number		29d. Date sign	gti (Month, Æ	Day, Year)
	FSFO		552749		01/	16/0	1
	2+1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gold Could Charles Street Ballimon	ma	21	230	
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1110	5.7		
	Regist		JAN 2 1 2005 General to Small				

Amend item#11,19a, perint in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- State of Maryland / Department of Health and Mental Hygiene

1- State of Maryland / Department of Health and Mental Hygiene

23a-b&27 per me G839 1-25-05 tas

1. Decedent's Name (First, Middle, Last) Erik Holien 05-00245 dl3. Time of Death Month Day **Physician** Holien Erik Holien Stephen aka 10, 2005 11:50 A January /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Green Delt

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12-06-1958 Prince George's 4 E. Hillside Road Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 18 M 2□F 212-78-2573 MD Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County r than "natural", or Itams 23a or 28a-f ahow the Medical Exemenational be politified at 1 Yes 2 XNo Directo MD Greenbelt Prince George 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20770 4 E Hillside Rd. USA r death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itan any injury or other traumatic evant, the Medical Exam. once. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1982-1986 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌣 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) Landscaper Maintenance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Wayne Allen Holien Mary Anne Holien 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 E Hillside Rd. Greenbelt MD 20770 19a. Informant's Name/Relationship (Type, Print) nne Holien (wife) Linda Lee 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) Chesapeake Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 01-13-2005 Beltsville '4 □ Donation 5 □ Other (Specify)

21. Signature of Furieral Service Licensee 22. Name and Address of Facility
Rapp Funeral & Cremation Services
933 Gist Ave Silver Spring MD 20910 232 Park. Enter the disease, Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cirrhosis of the Liver /Medical Due to (or as a consequence of): **Examiner** Chronic alcohol abuse Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician a hed for use as the burial-Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) I Yes 2 No 9 Unknown 9 Unknown signed by to Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown has been sige 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2 \sum No 24a. Was an autopsy performed? page . Yes Yes this certificate 2 □ No or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SCENE 1X Yes 2 No 2 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification; Injury 5 Pending 1 Xatural 1 ☐ Yes 2 ☐ No investigation death, 2 Accident within 24 hours after death To the Funeral Director: in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medi the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertified

State Registrar

31. Date filed (Mon) A.W. 2001 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201

OCME

January 11, 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. Np. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician TANLIARY HDY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Northwest Kandallstown Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 218 · 38 · 3/25 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 100M 20F Months 62 Yrs. MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or iteme 23a or 28a-f show other traumatic event, the Medical Exacting must be notified at Baltimore MD Randallstown 1 ☐ Yes 2 X No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Circle 9934 21133 Hout 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry s and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) STATE OF MD STATE TROOPER 12th grade 17. Father's Namo (First, Middle, Last) NIA 18. Mother's Name (First, Middle, Maiden Sumame) Be Alvin Jones Jewel Dalesbu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Chr. or Town, State, Zip Code) 9934 Hout Circle Randalstown, MD 21133 Evelun M. Jones, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 0 = 1 🔀 Burial 2 □ Cremation 3 □ Removal from State ŏ Gamison Forest Owings Mills, MD * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funda I Service Licensee 22. Name and Address of Facility
Value n. C. Grelne Funeral Services
5157 Manno Nathral Pile Pulls Mo 21229 23a. Part1. Entiritie disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. au Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit Due to (or as a consequence of): as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.0. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by ulimpuare 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 2 No 1 Tyes 1 Yes 2 1 N director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient ၉ 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA this Many of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury at Work? Hospitel or Attending 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) INPERIM

Registrar

State

31. Date filed (Month, Day, Year)

2005

			1 _ State	aryland / Department of Health and M Certificate of Death		2000 111368
			1. Decedent's Name (First, Middle, Last)	Commente of Dean	Rag, N 2. Date of Death	3. Time of Death
	Physicia		Sandon F. J	ones		2 2005 2125 M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number	4b. City, Town, or Location of Death		4c. County of Death
			Coastal Hospice at -	he Lake Salisbur		WICOMICO
	Funeral Director		216-64-9412 10M 2015	ge (In yrs. last birthday) Syrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Pate of Birth (Month, Day, Yea (NOV 2 /	9. Birthplace (State or Foreign Country)
	and sw		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
	Many -1 sho	tor	MD Somerset	Princess Ann		1 DYes 2 □ No
	h the	irec	10e. Street and Number	10f. Zip Code	10g. 0	Citizen of What Country?
	th wit	ai D	11689 Reachwood S	1 21853		USA
	ar dea	nue	11. Marital Status 12. Was Decedent Armed Forces	If Yes, specify Cuban, Mexican, Puerto I	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Hygiene natural; or flams 23a or 28a-f show ant, the Medical Exammer must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ 3 ☐ Widowed 4 ☑ Norced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: \albita
Š	2 hou atura	ted	15. Decedent's Education	16a. Decedent's Usual Occupation	16b.	Kind of Business/Industry
215	thin 7 e. an "n Med	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give kind of work done during most of working life. DO NOT use retired)	ng C	11111
2	led wi lygien her th			Housekeeping	(First, Middle, Maid	ando/Hotels
Maryland 21215-0036	ould be til Mental H arked otl atic evar	Ве	17. Father's Name (First, Middle, Last)	\ \A	(First, Middle, Maid	E + (lov
Ž	should hind Ment	2	19a, Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rur	Route Number, City	y or Town, State, Zip Code)
	and 2 sealth ar n 27 is		Thomas Jones	11689 Reachused St	Princess	Ann MD 21853
Je,	ss 1 and of Head item		20a. Method of Disposition	20b. Place of Disposition (Name of Disposition (Name of Disposition (Name of Disposition))		Location - City or Town, State
<u><u>E</u></u>	Pages nent of I ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 ☐ Donation 5 ☐ Other (Specify)	Metro Crematory 1/2	5 05	Balto MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Express. The must be notified at once.		21. Signatur of Funeral Service Licensee	22. Name and Address & Facility 11 A N 1 2 3 2 M 1 c	4 41 / -	Jessep, PA18434
			23a. Part. Enter the disease, or complications that cause shock, or leart failure. List only one cause on each	d the death. Do not enter the mode of dying, such as cardiac oine.	or respiratory arrest,	Approximate Interval Between
	Pnysician		Immediate cause (Final disease r condition	the Breat Call		Onset and Death
	/Medical Examiner		resulting in death) Due to (or a:	a consequence of):		1.77
	- 27.4	ъ	Sequentially list conditions, if any, leading to immediate b. Due to (or a	a consequence of):		
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o	an an rial-tr			a consequence of):		
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d			
9	death certifica attending pt d for use as t	/Mec	IF FEMALE: 23c. If yes, outcome	o of programmy		
Вох	that the death cer ed by the attendir detached for use	by Physician/Me	in the past 12 months?	2 ☐ Fetal death 3 ☐ Ectopic pregnancy It time of death 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
o.	it the do by the tached	ysic	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown	tune of death.		
<u>a</u>	s that ned b	y Pł	Part II. Other significant conditions contributing to death	out not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
rds	w requires that been signed to should be det	ed t			1 🗆 Yes	2 No 3 Probably 4 □Unknown
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Œ =	The ate h page	Com			performed? 1 ☐ Yes 2 🛣	? death?
Vita	ician: sertific ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death		
of	Physician: this certific ral director,	-T	1 ☐ Yes 22 No Hospital: 154 Inpat 27. Manner of Death 28a. Date of Inj		me 5 Residence 28d. Describe how in	6 ☐Other (Specify)
on	th. After fune	tion	Natural 5 Pending (Month, D	ay'Year) Injury Work? M 1 ☐ Yes 2 ☐ No		1,
Division of Vital Records,	I or Attending Physicien: The tatter death. Diractor: After this certificate ha lin by the funeral director, page	Certification:	3 Suicide 6 Could not be 28e. Place of Ir	jury - At home, farm, street, factory, office to. (Specify)	28f. Location (Street City or Town, Sta	and Number or Rural Route Number,
Ö	tal or A	Cert	Tomoso Building, e	ic. (Specify)	Oily of Tomil, Oil	110)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one) Cartifying Physician: To the besis and manner s	of my knowledge, death occurred at the time, date and place, a of examination and/or investigation, in my opinion, death occurre tated.	and due to the cause ed at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	29c. License number	29d. [Date signed (Month, Day, Year)
/	ń		MACKEY	140 126278		1/18/05
	7		30. Name and address of person who completed duse of	PU. Box 1733 5-1154	1410	21801
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 1 200	Elecus S. Souls)´	

			_ State	of Maryla		artment of F <i>rtificate of</i> I			2000	5 01369	
			Registrar 1. Decedent's Name (First, Middle, Last)			rimodio or i	Douin	2. Date of Dea		3. Time of Death	
,	Physicia /Medic			Johnsto	o n			Januar		5 9:15am M	
į	Examin	er	4a. Facility Name (If not institution, give street and	number)			Location of Death		4c. County of De		
	Formand	-	Continuum Care 5. Social Security Number 6. Sex	7. Age (in vr	s. last birthday)	Sykes If Under 1 Year	V111e If Under 24 Hrs.	8. Date of Birtl	Carr		
	Funeral Director		041-54-6260 1 ¹ M ² X		Yrs.	Months Days	Hours Min.	(Month, Da) Aug. 1	7, Year) C 5, 1913 V	irthplace (State or Foreign Country) 'T	
ī	pu >		Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or Lo	nation				Tand Incide City City	
	faryla show	ō	MD Carroll	100.0	Sity, Town of Lo		:110			10d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	the h	Director	10e. Street and Number			Sykes 10f. Zip Code	ATITE		10g. Citizen of What C	A	
	death with the Maryland ms 23a or 28a-f show rnust be nutified at	i D	7309 Second Avenue				784		USA	,	
	ems 2	Funeral	11. Marital Status 12. Was I	Decedent Ever in d Forces?	U.S. 13.	Was Decedent of H		ecify Yes or No-			
9	n 72 hours after death with the Marylan "natural", or Items 23a or 28a-f show ndical Examiner must be rediffed at	by Fu	1 Never Married 2 Married 1 Yes	es 2 7 No . Give X		1□Yes 2☑No	Specify:	7,000,	Specific		
2-003p	tural	ed b	15. Decedent's Education	or Dates:	16a, Dece	dent's Usual Occup	ation		16b. Kind of Busines	White	
0	within 72 ene. than "nat	Completed	(Specify only highest grade complet	ed) ge (1-4 or 5+)	(Give	kind of work done DO NOT use retired	during most of work d)	ring		,	
V	filed wil Hygien ther the	Con	8		Tea	acher			Education		
	ed also	Be	17. Father's Name (First, Middle, Last) Michael Cwikla						Maiden Sumame)		
Ž	should nd Mer marke	ဥ	19a. Informant's Name/Relationship (Type, Print)		19b. Maili	ng Address (Street	Josephi and Number or Rur		(NOWN) r, City or Town, State,	Zip Code)	
Z	od 2 lith a 27 Is		Mr. William M. Johnst	on (Son)					e, MD 2178		
e,	ite it		20a. Method of Disposition 1 ☐ Burial 2 【☐ Cremation 3 ☐ Removal fr	Chata	cemetery, cre.	osition (Name of matory or other place	e)	Date	20c. Location - City of	or Town, State	
DEL	Pages ment of tant: If it		`4 □Donation 5 □Other (Specify)	A1		y Cremat:			Sykesvill		
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee Wax L. Hay	+	1 2	ANGHT YU Sykesville	VERAL ^{iv} HOM ≥, MD 217	E & CHAI 84 (410)	PEL, PA (Be)-795-1400	ox 195)	
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л Э	hat the de id by the a detached		9 ☐ Unknown Part II. Other significant conditions contributing		esulting in the u	inderlying cause giv	en in Part I	23e Did to	bacco use contribute	to the cause of death?	
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ř	ysician: The lav is certificate has director, page 2	mo						autop perfor 1 Yes	med? / death?	completion of cause of	
Vital Record	cian: ertifica ector, p	Be C	25. Was case referred to medical examiner?				26. Place of Deat				
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DIVISION	r Attender death	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. P	lace of Injury - At	home, farm, st	reet, factory, office		28f. Location (S City or Tow	Street and Number or F m, State)	Rural Route Number,	
5	urs aft oral Di										
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To 2 Medical Examiner: On the and a	o the best of my kine basis of examinemanner stated.	nowledge, deat nation and/or in	th occurred at the tire	ne, date and place, pinion, death occur	and due to the dired at the time, of	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)	
	withi To t	Σ	29b. Signatule and title of Certifier	24 N	111	29c. Licens			29d. Date signed (Mor		
	1		20. Name and address of parson who completed	cause of death //	om 220) /Ture	Deint)	1034	215	01-10-	2009	
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	Sta Registr		JAN 2 1 2005	2. Registrar's Śig	t L	All is					

	·	1 - For State Registrar	State of Mary		partment of F ertificate of			Reg. No.200	5 01370		
Physicial /Medica Examine Funeral	al .	4a. Facility Name (If not institution, give Tohns Hopkins B. Social Security Number 6. S	exkins e street and number) expects Med ex 7. Age (In	cal Cont	BCL If Under 1 Year)	Day 17 2	A		
Director		213-03-4008 Usual Residence of Decedent 10a. State 10b. County	™ 2□F	85 Yrs.	Months Days	Hours Min.		29 , 1919	D. Birthplace (State or Foreign Country) PA. 10d. Inside City Limits		
with the Ma a or 28e-f	Funeral Director	MD. Baltimo 10e. Street and Number 7820 New Battle G		D	undalk 10f. Zip Code 212	222		10g. Citizen of Wh	1 □ Yes 2X No at Country?		
urs a	ص ا	11. Marital Status 1 Never Married 2 Married 3 Note: Married 4 Divorced	12. Was Decedent Ever Armed Forces? 1 XYes 2 No If Yes Gue Year or Dates:	in U.S.	3. Was Decedent of H If Yes, specify Cubin	Hispanic Origin? (S	Specify Yes or No to Rican, etc.))- 14. Race -	American Indian, White, etc. White		
d within 72 hor giene. or than "natura the Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12 years	ducation ide completed) College (1-4or 5+)	(Gi	cedent's Usual Occup ve kind of work done b. DO NOT use retired hinist Re	during most of wo.	rking	16b. Kind of Busin			
should be filed with nd Mental Hygiene. marked other that umatic event, the	To Be C	17. Father's Name (First, Middle, Last, Unknown 19a. Informant's Name/Relationship (10h Ma		18. Mother's Na	nown	, Maiden Sumame)	Tin Code)		
of Health and I tem 27 ts m	10,000	Beverly Harris 20a. Method of Disposition	Daughter	781	illing Address (Street 8 New Batt position (Name of rematory or other place	tle Grove			d. 21222		
permit. Pages 1 al Depertment of Hea Importent: If Item any injury or othe 20008.		1 Burial 2 X remation 3 4 Donation 5 Other (Specification 5 Specification 5 Specification 21. Signature of Funeral Service Licer	y)	Bayview	Crematory 22. Name and Addre Connelly I	Y 19	,2005 Home Of I	Baltimore Dundalk,P	.A.		
Physician /Medical Examiner		23a. Part1 Enter the disease, or com shoot, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line. a. Pheumo	death. Do not e	7110 Solle				Approximate Interval Between Onset and Death		
	cai Examiner										
The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	3 □Ectopic pregnanc; 5 □ Other (specify) _	у		23d. Date of Month	,		
law requires that las been signed b	by	Pan II. Other significant conditions of	ontributing to death but no		e underlying cause give		23e. Did to	\ \ \ \	ute to the cause of death? Probably 4 □Unknown		
sicien: The law certificate has b rector, page 2 st	e Completed	25. Was case referred to medical				De Place of De	24a. Was autor perfo	psy priormed? dea 2 No 1	re autopsy findings available or to completion of cause of tth? Yes 212No		
ng Phys	ation: To B	examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending 2 Accident investigatio	Hospital: 1 Inpatient 28a. Pate of Injury (Month, Day Ye	2☐ ER/Outpat 28b. Time Injur	e of 28c. Injur	ner: 4 🗆 Nursing H	lome 5 ☐ Resid	dence 6 Other	(Specify)		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the ft	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	building, etc. (S	pecify)		· · · ·	City or Tov	wn, State)	or Rural Route Number,		
To the Hosp vithin 24 hour fo the Fune	Medical	29a. Certifier (Check only one) 2 ☐ Medical Example 29b. Signature and title of certifier	ysician: To the best of miner: On the basis of exa and manner stated.	y knowledge, de mination and/or	ath occurred at the tir investigation, in my of 29c. Licens	opinion, death occu	irred at the time,	cause(s) and mann date and place, and 29d. Date signed (i	d due to the cause(s)		
P	}	30. Name and address of person who				0			in 17, 2005		
Stat	•	Laura Hannek J 31. Date filed (Month, Da), Year)	132. Registrar's		Stern A	ve, Bal	Amore	, MD 3	1224		

VERNON J. JORDAN 05-00406 Please Type of Print in Black indensity in the Americal Programment of Health and Mental Hygiene For Amend Item 1&Unipend Item 23a&27 ner me G940 2-7-05 tas

Reg. No. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. RKD Reg. No: 1. Decedent's Name (First, Middle, Last)
Vernon J. Jordan
Vernon J. Jordan, 2. Date of Death JANUARY Physician 2005 17, 12:33P. /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1003 RODMAN WAY BALTIMORE N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) April 17, 1965 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State of Foreign Country) 137 y and **Funeral** Months 1**X** M 2□ F Yrs 39 Director 214-86-1579 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1X Yes 2 No Maryland N/A Baltimore Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4023 Raymonn Avenue 21213 u. s. Α. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 X No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade Painter Construction other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental and Mental Vernon J. Jordan, Sr. Joanna M. Jordan 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trai Joanna Jordan (Mother) 4023 Raymonn Avenue, Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Bauview Crematory 1/20/2005 Baltimore. Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes عكر Barros 3331 Brehms Lane, Bactimore, Mary Land 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last certificate be executed burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the of Vital Records, P.O. detached 9 Unknown 9 Unknown þ s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 **X**Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No has page 2 certificate 1 💢 Yes 2 No 25. Was case referred to medical examiner?

1 XYes 2 No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE 2 this funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: After Division or Attending 5 Pending investigation 1 XNatural death. 1 ☐ Yes 2 ☐ No Accident Director: 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by after 4 Momicide within 24 hours a To the Funeral 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as occurred at the time, date and place, and due to the cause(s) and manner stated. icai 29a. Certifier (Check only one) completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) h O.C.M.E. JANUARY 18,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING 111 PENN STREET BALTIMORE, MARYLAND 21201 mid

State

Registrar

31. Date filed (Month, Day, Year) JAN 2 1

32 Registrar's Signature

2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 5:30 Frances H. Jones January 19, 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mariner Health of Catonsville Catonsville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 X F 220-48-1855 Director 93 April 27, 1911 Delaware Usual Residence of Decedent permit. Pages 1 and 2 should be lited within 72 hours after death with the Maryland Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumatic event, the Modical Examiner must be proved to 200. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2X No Director Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21228 USA 2418 Rockwell Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: White þ 3 ™ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Robert Hopfer Helen Lepley Nott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard H. Jones, III 2418 Rockwell Avenue; Catonville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. John Cemetery 1/21/2005 Ellicott City, MD 4 □ Donation 5 □ Other (Specify) Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee tellest 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YOCARDIAL INFARCTION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY 1 Yes 2 No 3 Probably 4 Donknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy After this certificate 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospitel or Attending 5 Pending 1 Yes 2 No investigation death. 2 Accident Director: the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours 29a. Certifier 1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exam (Check only er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) onel 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of confide 2 057722 M.D JANUARY 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE NATIONAL PILE #603 BALTIMURE MD 21228 LEDVARD RICHARDSON M.P. 5602 32. Resistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

2005

Physic	an	1. Decedent's Name (First, Middle, L.	Rosa Jones	Toney		1 1	Day Year 3. Time of De
/Medi		4a. Facility Name (If not institution, gi		4h Ci	y Town orlanding of Bank	1	6 2005 5.15
Examir	er	4a. Facility Name (if not institution, gr	n:10ha8Ls n	, CIR -	ty, Town, or Location of Dea	un	4c. County of Death
Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs. Id		ler 1 Year If Under 24 Hrs		9. Birthplace (State or F
Director		215-12-7776A Usual Residence of Decedent	10M 20F 32	Yrs. Month	s Days Hours Min	. (Month, Day, Yea	9. Birthplace (State or For Country) 122 South Care
-f show	. [10a. State 10b. County	10c. City	, Town or Location			10d. Inside City L
rai', or items 23a or 28a-1 sho Examiner must be notified at	Funeral Director	MARYLAND N/A	Bu	ALTIMO	ne		1 □ Yes 2
ene. than "natural", or items 23a or 28a he Medical Eraminar must be noti	Dire	10e. Street and Number	~	10f. 2	Zip Code	10g. (Citizen of What Country?
s 23a nust t	rai	1520 TERRY		D	21225		USA
item	une	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. Was Dec	edent of Hispanic Origin? (S becify Cuban, Mexican, Puer	Specify Yes or No- to Rica <i>n,</i> etc.)	 14. Race - American Indian, Black, White, etc.
9 0	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes 2 1000 If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: BLACK
"natural", dical Era	ted	15. Decedent's E	ducation	16a. Decedent's Us	sual Occupation	16b.	Kind of Business/Industry
Media	Completed	(Specify only highest gi Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of v life. DO NOT	vork done during most of wo	rking	
giene ar tha	E O	6Th GRADE	College (1-401 3+)	Dor	MESTIC	1	RIVATE
Mental Hygiene arked other than atic event, Ite	Be (17. Father's Name (First, Middle, Las	1)		18. Mother's Na	me (First, Middle, Maide	
Ment arked atic e	70	LESTUS JO	NGS		VIRG	INIA T	hompson
and s m		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Addre			or Town, State, Zip Code)
Health tem 27 i		,	- NEphow	1525			Timor MD
or othe		20a. Method of Disposition 1		ace of Disposition (Nimetery, crematory or	other place)		Location - City or Town, State
Department of important: If eny injury or once.		' 4 □Donation 5 □Other (Spec	(v) N	T210N		22-05 L,	AND SDOWNE W
Departimbor eny in once.		21. Signature of Funeral Service Lice	nsee	22. Name	and Address of Pacility	PARKON FI	Thomas Jon View
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ysician Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	one cause on each line.	reland	1 ((R 8 RM)		Approximate Interval Between Onset and Dea
kaminer			Can	000 ew	anen	1.0-08	43
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):	1.101	d Dess	
n and ial-transit	Examiner	that initiated events	cS	9 Cr51	DECHEST	g vicer	-
ician a burial-		resulting in death) Last	Due to (or as a consequ				
38	licai	•	d	Dem	ents		
ding ph	/Me	IF FEMALE:	00-16				
by the attending r tached for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 □Ectopic			23d. Date of delivery Month Day Year
igned by	4	Part II. Other significant conditions	contributing to death but not resu	Iting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to the cause of deatl
(7) T3	d by	Cardio	-pulmong	ry er	rest	1 ☐ Yes	2 ⊠ No 3□Probably 4□Unkr
been	Completed					24a. Was an	24b. Were autopsy findings ava
page 2	E D					autopsy performed?	prior to completion of cause
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is certific director,	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 🔀	ER/Outpatient 3□ E	Othor	ath (Check only one)	6 Moha (O 4)
er this neral d		27. Manner of Death		28b. Time of	28c. Injury at Work?	lome 5 Residence 28d. Describe how inj	
After funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury M	Work? 1 ☐ Yes 2 ☐ No		
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s after death. ii Director: A id in by the fu		29a. Certifier 1X Certifying P	nysician: To the best of my know miner: On the basis of examinati and manner stated.	rledge, death occurre on and/or investigation	d at the time, date and place on, in my opinion, death occu	a, and due to the cause(urred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
i 24 hours after death. le Funeral Director : After this certifics letely filled in by the funeral director, i		(Check only 2 Medical Exa	and marmor otatod.				
within 24 hours after death To the Funeral Director: / completely filled in by the f	Medical	(Check only 2 Medical Exa	and marrier states.	2:	9c. License number	29d. D	ate signed (Month, Day, Year)
within 24 hours after death To the Funeral Director: , completely filled in by the f		one)	- S	25	9c. License number 30)15		ate signed (Month, Day, Year)

				partment of Health and Mental Hygerificate of Death	giene2005	01374
	Dharisi		Decedent's Name (First, Middle, Last)	2. Date of Dea		3. Time of Death
	Physicia /Medic		BEVERLY M Jons	9.11	10 200	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Baltimore	4c. County of Death	
H	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F F 7. Age (In yrs. last birthda	Months Days Hours Min. (Month, Day	y, Year) Cou	nplace (State or Foreign untry) MD
	D > 0		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
	Aaryla f sho	or	MD NA Balti			1 X Yes 2 □ No
	r 28a-	rect	10e. Street and Number		10g. Citizen of What Cou	untry?
	th with	al D	5315 Gist Ave	21215	U.S.A	Α.
10	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or Itama 23e or 28e-f show any injury or other traumatic avent. Its Medical Evant at must be muitible at ODG.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Amer Black, White	
21215-0036	ural, o	d by	3 ☐ Widowed 4 ⚠ Divorced Year or Dates:	1 ☐ Yes XQNo Specify:		Black
7	in 72 n "nat	olete	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ive kind of work done during most of working b. DO NOT use retired)	16b. Kind of Business/l	noustry
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nd	be file tal Hy d oths avent.	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	Maiden Sumame)	
Maryland	hould d Men marke matic	ဥ	Samuel Gibbs 19a. Informant's Name/Relationship (Type, Print) 19b. Ma	Florence May ailing Address (Street and Number or Rural Route Number	er City or Town State 7	in Code)
Z	ulth an all the an all the art is a contract.			9 Arrowhead Road, Pike	*	
re,	of Hearlitem		20a. Method of Disposition 20b. Place of Dis	sposition (Name of Date rematory or other place)	20c. Location - City or	
Ē	Page ment c ant: if ury or	1		Crematory Inc. 1/19/05	5 Baltimor	ce, Md
Baltimore,	permit. Depart Import any inj		A While C During	22. Name and Address of Facility March F/H West 4300 Wabash Ave, Balt:		21215
			231. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Prysician		Immediate Cause (Final disease or condition resulting in death) a	y Hypertension		days
	/Medical Examiner			mass		Vair
4		Jer	Sequentially list conditions, a.y, beautiful in mediate cause. Enter Underlying			1-1-1-2
	icuted nd transit	Examiner	that initiated events			
8760,	cate be executed physician and s the burial-transit	dlcal Ex	resulting in death) Last Due to (or as a consequence of):			
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Вох	death certific e attending p ed for use as	Physiclan/Me		3 ☐ Ectopic pregnancy	23d. Date of deli Month	very Day Year
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Sor	> 11 (2)	letec	chemotherany, radiatio	√ 24a. Was	an 24b. Were au	topsy findings available
Vital Records	e la has ge 2	Completed		autop	osy prior to c death?	completion of cause of 2 No
/ita	yaician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only of		
of	S 0 0	- T	1 Ves 2 No Hospital: Inpatient 2 Ft/Outpa 27. Magner of Death 28a. Date of Injury 28b. Time		dence 6 Other (Spec now injury occurred	cify)
on	Jing After fune	tlon	↑ Natural 5 ☐ Pending (Month, Day Year) Injur 2 ☐ Accident investigation		,	
Division	i or Attandii after death. Diractor: Ai	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 28f. Location (\$City or Tow	Street and Number or Ru vn, State)	ral Route Number,
	Hospitei o 14 hours af Funerai D tely filled is		29a. Certifier TO Certifying Physician: To the best of my knowledge, do	eath occurred at the time, date and place, and due to the	cause(s) and manner as	stated.
	To the Hospitei within 24 hours a To the Funeral I completely filled	fedical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	r investigation, in my opinion, death occurred at the time,	date and place, and due	to the cause(s)
	To To To To To To To To To To To To To T	Z X	29b. Signature and title of certifier SURGICAL YPS		Jan 10/	
0	11/0		30. Name and address of person who completed cause of death (Item 23a) (Type Complete Cause of Death (Item 23a) (Type Complete Cause of Death (Item 23a) (Type Cause	pe, Print)		
			31. Date filed (Month, Day, Year) 32. Registrar's Signature	•		
	Regist	ate rar	JAN 2 1 2005			

		1- For Unpend Item 2 Registrar	35tat9 05Maryla	od Department Ce.	ortificate of	e ol th ead Death	Mental Hyg	iene 005	01375	
Physic		1. Decedent's Name (First, Middle, Last					2. Date of Deat	h	3. Time of Death	
Physici /Medio		ANTHONY R. JONES					JANUARY	13. 2005		
Examin	ner	4a. Facility Name (If not institution, give PRINCE GEORGES HOS	street and number) PITAL CENTER		4b. City, Town, o CHEVE	Location of Deal		4c. County of De PRINCE G	ath	
Funeral Director		5. Social Security Number 6. Se 578-84-1417 Usual Residence of Decedent	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	9. 8 15, 1959	irthplace (State or Foreign Country) Washingtonl	
ryland how		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits	
e Ma Sa-f s	cto	D.C			Washi	ngton			1 ☑ Yes 2 ☐ No	
vith th	Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What 0	Country?	
eath y	erai	4300 F.St. S.E.	12. Was Decedent Ever in U	10 10		20019		Jnited Sta		
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinations to collined at	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ₩ No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh Specify: P	ite, etc.	
ithin 72 ho ne. nan "natur nedical	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	uring most of wo	rking	16b. Kind of Business/Industry		
led within 72 hours aft lygiene her than "natural", or nt, the Medical Exerci		12th			Maint	enance w			enance	
id 2 should be file th and Mental Hy 27 Is marked oth traumatic event	Be	17. Father's Name (First, Middle, Last)					me (First, Middle, N	,		
hould Me	٩	James H. Jones 19a. Informant's Name/Relationship (T)	rna Printl	10h Mailie	Address (Character	The state of the s	rine Ches	2		
nd 2 s lith an 127 is rtrau		Aretha Jones/Siste	, . ,				Hills, M	City or Town, State,	Zip Code)	
s 1 ar f Hea ltem		20a. Method of Disposition	20b.		sition (Name of natory or other plac			20c. Location - City o	r Town, State	
Page ent c nt: If ry or		1 Burial 2 □ Cremation 3 □ F `4 □ Donation A 5 □ Other (Specify)	ioniovan nomi otato		ret Cemeto	i	-05 W	ashington	D C	
in just		21. Signatur of Funeral Service Licens			. Name and Addres				tuary Inc.	
Per Dep Imp any		Maron	HAVINGO	Mey	25 Maryla	and Ave.			D.C. 20002	
cate be executed by physician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate 31.3 For a condition of the cond	Due to (or as a consect							
death certifi e attending id for use as	Physician/Medicai	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d. 3c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	at death 3 ☐ death 5 ☐	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year	
The law requires that the tite has been signed by the bage 2 should be detache	by	Part II. Other significant conditions cor	tributing to death but not res	ulting in the ur	nderlying cause give	n in Part I.			o the cause of death?	
	e Compieted	25. Was case referred to medical					24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of	
Physician: this certific ral director,	o Be	examiner?	ospital: 1 Inpatient 2X	VED/Outsetun	Othe		th (Check only one			
	P-	27. Manner of Death	28a. Date of Injury	ER/Outpatien 28b. Time of	28c. Injury	at	28d. Describe hov	nce 6 Other (Special of the following occurred of the following occurred of the following occurred of the following occurred of the following occurred of the following occurred of the following occurred of the following occurred of the following occurred of the following occurred of the following occurred of the following occurred of the following occurred of the following occurred occur	ecity) u nk	
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2 5 5	Certification:	3 Suicide 6 A Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif Found at hor	ne		,	lashingto	n,D,G,	Street, S.E.	
Hosp 24 hor Fune tely fi	dical	29a. Certifier (Check only one) 1 Certifying Physical Examination	sician: To the best of my kno ner: On the basis of examina	owledge, death ition and/or inv	occurred at the tim estigation, in my op	e, date and place nion, death occu	, and due to the cau	use(s) and manner a se and place, and du	s stated.	
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Med	29b. Signature and title of certifier	and manner stated.	1	29c. License	number	296	d. Date signed (Moni	th, Day, Year)	
Beth		30. Name and address of person who co	mpleted cause of death (Item	n 23a) (Type, I 2111 T	Print) PENN STREI	ET,BALTI		YLAND 212		
7						,	,			

		1 - For State Registrar	. 1040	State of		d / Depa		of H	ealth a		lental Hy		05	01376
		Decedent's Name	(First, Middle, L	ast)			-				2, Date of De			3. Time of Death
Physi		Hansa	Jos	hi							Month 01	Day 17	2005	11:40a M
/Med Exam		4a. Facility Name (If	not institution, g	ive street and numb	per)		4b. City, 7	Town, or	Location of	of Death			unty of Death	
LAGIII	illei	8823 Woo					, ,		Spr					
Funera		5. Social Security Nu		Sex 7	. Age (In yrs. la	ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bin (Month, Da	th	ontgom 9. Bint	place (State or Foreign intry)
Directo		220-92-7	651	1 □ M 2 🔼 F	88	Yrs.	Months	Days	Hours	Min.	03-14	y, Year) -1916	In	dia
P .		Usual Residence of												
arylar show	_	10a. State	10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
Ba-f	cto	MD	Montgo	mery	882	3 Wood	lland	Dr S	Silve	r Sp	ring MD	20910)	1 ☐XYes 2 ☐ No
or 2	D i	10e. Street and Num			_		10f. Zip	Code				10g. Citizen	of What Cou	intry?
ath w	<u>ra</u>	8823 Wo	odland	Dr Silver						910		USA		
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. kther then "neturel", or Items 23a or 28a-f show ant, the Marical Examinant the notified at	Funeral Director	11. Marital Status		12. Was Deced Armed Forc	es?	S. 13.	Was Decede If Yes, speci	ent of His fy Cubar	spanic Ori n, Mexican	gin? (Sp i, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Amer Black, White	ican Indian, , etc.
36 saft	by F	1 ☐ Never Marrie		1 ☐ Yes 2 If Yes, Give Year or Date			1 □ Yes 2	XM Vo	Specify:				ecify: Wh	
Pour turnel	Pe		15. Decedent's		95.	16a Daca	dent's Usual	Ossuss	tion					
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with iene.	l Eo	Elementary/Secon	dary (0-12)	College (1-4	lor 5+)		acher	ĺ				Sc	hool s	System
Hyg other	BeC	17. Father's Name (i	First, Middle, Las			10	acher		18. Mothe	r's Name	(First, Middle,			
Maryland 21215-0036 d 2 should be filed within 72 hours aff th and Mental Hygiene. th is marked other than "neturel", or traumatic event, the Madical Exernitation	To B	Ghanana	nd Pant						Pa	rvai	i Bhati	F		
aryla should and Men marke umaric	-	19a. Informant's Na	me/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a			I Route Numbe		wn, State. Zi	p Code)
Md 2 lith a 27 is r trau		Pratib	ha Josh:	i		42/07/2012					er Spr			
S 1 a t Hee		20a. Method of Disp	osition		1 00	ace of Dispo	sition (Nam	e of			Date		on - City or T	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturet; or Items 23a or 28a-f show any injury or other traumatic event, the Marical Execute an usine profited at		1 ☐ Burial 2 ☐		□Removal from St	ate	-	•	,	´	01-1	8-2005	D ∩ 1 +	sville	
alti	ė	21. Signature of Fur			11	/ 22	. Name and	Addres	s of Facilit	y				
Dermi Depa Impo eny is	Į.	1000	5 6 7	(X / 1) [Van		Rapp 1	Fune	ral 8	Cre	emation er Sprin	Servi	ces	
		23a. Part1. Enter the shock, or hear	e disease, or co	mplications that cau	sed the death	. Do not ent	er the mode	LST of dying	AVA C , such as	cardiac	or respiratory ar	rest,	20910_	Approximate
Physiciar		Immediate Cause (F	Final	y one cause on eac	SPIRA	A TOR	4	FI	AIL	1)0	5			Interval Between Onset and Death
/Medica		disease or condition resulting in death)		_ d					,	0 /				GRICE
Examine	r			P	as a consequ	MO	NH							4 DAYS
	e le	Sequentially list con if any, leading to min cause. Enter Under Cause (Disease or i that initiated events	ditions, nediate	D	as a consequ			_						
uted d ansit	Examiner	Cause (Disease or in that initiated events	njury											
D, exec in an ial-tr	Exa	resulting in death) L	ast	Due to (or	as a consequ	ence of):								
68760, ificate be executed g physician and as the burial-transit	cai			d										
68 tiffica ig phy as th	edi													
Box eath cert attendin for use	Ş	IF FEMALE: 23b. Was decedent		23c. If yes, outco	me of pregnar h 2 🗆 Fetal		Ectopic pre					23d.	Date of deliv	ery
deat death	icia	in the past 12 r		4□Pregnar	nt at time of de		Other (spe						Month	Day Year
cords, P.O. Box 6i vequires that the death certific been signed by the attending p should be detached for use as	Physician/Med	9 Unknown	`	9□ Unknow	m									
S, F as the gned	by F	Part II. Other signification	cant conditions	contributing to dea	th but not resu	Iting in the u	nderlying ca	use give	n in Part I.		23e. Did to	obacco use d	contribute to	the cause of death?
v require							_				101	res 2 N	o 3∏Pro	bably 4 □Unknown
Records, he taw requires the has been signe	Completed										24a. Was		4b. Were auto	opsy findings available
The tav	E O											rmed? 2 XNo	death?	ompletion of cause of
vision of Vital Records, P.O. Box 68 Attending Physiclen: The law requires that the death certifica death. sctor: After this certificate has been signed by the attending ph by the funeral director, page 2 should be detached for use as it	BeC	25. Was case referre	ed to medical						26. Place	of Death	(Check only o		10163	2010
on of Vita ding Physiclen: h. After this certific tuneral director,	To E	examiner?	10	Hospital:	oatient 2 🗆 E	ER/Outpatier	it 3 🗆 DOA	Othe	r: 4□Nui	rsing Ho	ne 5 Resid	dence 6 🗆	Other (Speci	fy)
ng Ph ter th		27. Manner of Death	5 C Paradian	28a. Date of	Injury Day Year)	28b. Time of	28	c. Injury Work	at		28d. Describe h			,,
ath.	atic	1 Natural 2 Accident	5 Pending investigati	on	,	,,	М		es 2 🗆 l	Vo				
Division of or Attending Physafter death. Director: After this in by the funeral d	ti Ei	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 28e. Place o	f Injury - At hor	me, farm, str	eet, factory,	office			28f. Location (S City or Tox	Street and No	umber or Run	al Route Number,
tal o	Certification:			Callaling	, oto. (opoony)	,					Only or Ton	ni, Siale)		
Division (To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier (Check only	Certifying F	Physician: To the basiner: On the bas	est of my know	viedge, deat	occurred a	t the time	e, date and	d place,	and due to the	cause(s) and	manner as s	stated.
the H in 24 the F iplete	ledical	one)		and manne	r stated.	- Ion and or in	vestigation,	in my op		- OCCUIT	ed at the time, t	date and pla	ce, and due t	o the cause(s)
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	4		-azijo	, ag	w.		1	1	814	5				2005
3	-	30. Name and addre	ss of person wh	completed cause	of death (Item	23а) (Тура,	Driet		= 1 .	14	7171	ADO	110	20774
		DAVID A	, 900	PNY PW.	1430	rie l	U NI	ر حسال	= -/\	/. TT	メノナン	·· 1260	, MO,	20774
	tate	31, Date filed (Monti	JAN 2 1	2008 32. Rec	ars Signat	ure	,a							
Regis				2003	Colum	K	anne.	,						
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			1 - For Stata Ragistrar	State of N	laryland / Dep <i>Ce</i>	artment of Fertificate of			giene Rag. NQ: 11	O F	01077
			Decedent's Name (First, Middle, Last)				2 Date of Dea	ath	79	3. Time of Death
	Physici		David Jack Jordan					Januar	Day 15	Year 2005	1135 AM
13	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of Death		4c. County of Death		
			U/// Teres		OSPITAL	Baltimor				n/a	
	Funeral Director		5. Social Security Number 6. Se 213-32-5406	x 7. A ☐ M 2 ☐ F	ge (In yrs. last birthda) 68 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 11-12-	36 Year)	9. Birth Coul Mary L	place (State or Foreign ntry) and
	pur A		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation					10d. Inside City Limits
	darylan f show	ō	Maryland n/a		Baltimo						1 Yes 2 □ No
	288-	Director	10e. Street and Number		Datchio	10f. Zip Code			10g. Citizen of	What Cou	ntry?
	3a or		902 Kenwood Avenue			21205			USA		
	death ms 2	Funeral	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U.S. 13	Was Decedent of H	lispanic Origin? (Sp	pecify Yes or No-	14. Ra		can Indian,
36	be filed within 72 hours after death with the Maryland hat Hygiene. od other then "neturel", or items 23a or 28a-f show event, I're Mydical Examinar must be multified at	by Fu	Never Married 2 Married 3 Widowed 4 Divorced	1X Yes 2 If Yes, Give] No	1 ☐ Yes 2 No	Specify:	nican, etc.)		ick, White, fy: Blac	
21215-0036	hour		15. Decedent's Edu			edent's Usual Occup	ation		16b. Kind of B	lusiness/lr	dustry
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212	d within giene. Ir then "	mo;	11th	College (1-4o	Cra	ne Operator			Bethleher	n Stee	1
9	be filed tat Hygie d other event, II	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Sumai	ne)	
yla	should be nd Menta marked umatic ev	2	David Hayden				Golden S	S. Dillon			
Maryland	2 6 8 7		19a. Informant's Name/Relationship (T)			ing Address (Street					Code)
	s 1 and 2 f Health item 27 I		Catherine Anderson/Fri	end	2611 20b. Place of Disp	Monument St		more, Mar	yland 212 20c. Location		Charles Charles
õ	0 0 = =		XX Burial 2 Cremation 3 DF		cemetery, cre	ematory or other place	ce) 1 in				
Baltimore,	permit. Pag Department Importent: I eny injury c		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service Licens			n Cemetery 2. Name and Addre		21/05	Langu	wire.	Maryl.and
Ba	permit. Departr Importe eny inju		Somedo V	mas_		Wlie Funera	1 Home, 638		-	Balto.	Maryland 21217
			23a. Part1. Enter the disease, or companies shock, or heart failure. List only	ications that cause ne cause on each	line.				rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Cere	6 ro rusco	dur c	recide	M			Oriset and Death
	/Medical Examiner		resulting in dealiny	Due to (or a	s a consequence of):	len	erceide ermoni	la			
		-	Sequentially list conditions, if any, leading to immediate	Due to (or a	s a consequence of):	fine					
	uted 1 ansit	min	cause. Enter Underlying Cause (Disease or injury								
Ć	exec an and rial-tra	Examiner	that initiated events resulting in death) Last	Due to (or a	s a consequence of):		, 1	****			
8760,	cate be executed physician and the burial-transit	dlcal	(. En	stoge	renal	! Sis	serk			
9		Wed	IF FEMALE:								
Вох	death certific e attending p id for use as	an/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	☐Ectopic pregnancy	(ate of delive	ery Day Year
0.	0 0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown	at time of death 5	Other (specify)				<i>y</i> 101	Day Toal
Δ.	that the		Part II. Other significant conditions co	ntributing to death	but not resulting in the	underlving cause giv	en in Part I.	23e. Did to	bacco use con	tribute to ti	he cause of death?
rds,	S P 9	ed by				, , ,			es 2 🗆 No	3 🗌 Prob	_
Record	aw require s been sig 2 should b	Completed						24a. Was a		Were auto	psy findings available
R	The lav ate has page 2	mo						autop: perfor 1 ☐ Yes	med?	death?	mpletion of cause of
Vital		Be C	25. Was case referred to medical				26. Place of Deat				
of V	g .s .g	2	examiner? 1 ☐ Yes 25 No	lospital: Inpa	ient 2 ER/Outpatie	int 3□ DOA Oth	er: 4 Nursing Ho	ome 5 🗆 Resid	ence 6 🗆 Oth	ner (Specif	y)
		on:	27. Manner of Death 1 Statural 5 ☐ Pending	28a. ate of In (Month, E	ury 28b. Time (ay Year) Injury	Wor	k?	28d. Describe h	ow injury occur	red	
sio	Attending or death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	201 1 11 12			
Division	_ 0	Certification:	4 Homicide determined	building,	njury - At home, farm, s etc. <i>(Specify)</i>	reet, factory, office		City or Tow		er or Hura	al Route Number,
	pitel Durs s erel filled		29a. Certifier 17X Certifying Phy	sician: To the hes	t of my knowledge dea	th occurred at the tir	ne, date and place	and due to the o	ausa/s) and m	20001 25 5	tated
	To the Hospitel or within 24 hours afte To the Funerel Direct completely filled in the funerel or the funerel Direct completely filled in the funerel or the	edical	(Check only 2 Medical Exami	ner: On the basis and manner	t of my knowledge, dea of examination and/or i stated.	nvestigation, in my o	pinion, death occur	red at the time, d	late and place,	and due to	the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number	C 2	9d. Date signe	d (Month,	Day, Year)
						32 1	5214	7	lanua	sy /	6.2005
	1		30. Name and address of person who co	ompleted cause of	Clan	Print 14	1- 000	me	217	3/	
			601 South	22 000	Sometice Signature	Dest	/ n	10			
ig (Sta Registi		31. Date filed (Month, Day, Year) JAN 2 1	2005 D	r's Signature	Soule					

Jordan, David

KIBLER, MARY

		1 = State Registrar 1. Decedent's Nan	ne (First Mide	tle (ast)			Ce	rtificate of	Death	· · · · · · · · · · · · · · · · · · ·	2. Date of I	Reg. No	400	15	3. Time of Deatl
Physici /Medi		Mary Ann								:	Month Jan.	Da	2005	Year	9:15pm
Examir	ner	4a. Facility Name 615 Taney	(If not institution Avenue	on, give stree	et and numb	oer)		4b. City, Town, o		of Death		4c	County F	of Death reder	ick
uneral irector		5. Social Security 349–30–9 Usual Residence	9757	6. Sex 1 ☐ M	2□F 7.	Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.		Birth <i>Day, Year)</i> 3/1901)	Coui	place (State or Fore ntry) aly
f show	tor	10a. State	10b. Count	y rederid	k	10c. City	y, Town or Lo	ocation	Fre	derid	ς				10d. Inside City Lim
3a or 28a st be noti	Funeral Director	10e. Street and No 615 Taney						10f. Zip Code 217	701			10g. Cit	itizen of W	Vhat Cou	ntry?
if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Marital Status		rried	Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	№ No		Was Decedent of I If Yes, specify Cub	an, Mexicai	n, Puerto	ocify Yes or I Rican, etc.)	No-		k, White,	can Indian, etc. hite
han "natur e Medical	Completed	Elementary/Sec	cify only high		ompleted) College (1-4	or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during mos ad)	st of worki	ng	16b. K	Cind of Bu		
ed other the	Be	12 17. Father's Name Vincenz	(First, Middle		5+			Physicia	18. Mothe	er's Name	(First, Mida		n Sumam	Medic e)	zal
27 is mark traumatic	70	19a. Informant's N						ng Address (Street	and Number	er or Rura	I Route Num	nber, City o	or Town, ;	State, Zip	Code)
Important: If Item 2 any Injury or other once.		20a. Method of Dis	sposition	3 □Remo	-	C	lace of Dispo emetery, crer	esition (Name of matory or other pla	1)ate	20c. Lo		•	own, State
Importa any Inju once.		21. Signature of F	uneral Service	Licensee	Metor 1	P. Doda,	Jr. 22	Name and Addre	ess of Facili	ty E Flanc	neal Lieu	no Troc	_		
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			1 - State Amend	Item	State o	f Marylan n G839	nd / Depa 1-21-05	rtment <i>tificate</i>	of H of L	ealth a D <i>eath</i>	and M	lental Hy	giene Reg. Ne	2005	01379
	Physic		1. Decedent's Name (Fin Pauline	rst. Middle. L	ast)							2. Date of De		y 2005	3. Time of Death 10:15a M
	/Medi Examir		4a. Facility Name (If not Shady Gro					4b. City, To		Location		gh	4c	County of De	gomery
Ī	Funeral Director		5. Social Security Numb	369	Sex 1 ☐ M 2 🗶 F	7. Age (In yrs. 94	last birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs Min.	8. Date of Bir (Month, Da	th Qan	27-19 1 0	rthplace (State or Foreign Country) PA
	and		Usual Residence of Dec 10a. State 10t	edent c. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	Mary	tor	MD	Mon	tgomer	7	Beth	esda							1 ☐ Yes 2 ☐ No
	3s or 28s	Funeral Director	10e. Street and Number 5910 Col	oalt	Road			10f. Zip 0		816			10g. Cit	izen of What C	country?
9	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show or other traumatic event, the Medical Exertinar must be notified at	/ Funera	11. Marital Status 1 ☐ Never Married		Armed Fo		1	Was Decede f Yes, specif	y Cubar	spanic Ori n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Am Black, Wh Specify:	
-003	hours tural',	ed by	3€ Widowed 4 □	Divorced Decedent's I	Year or D	ates:		lent's Usual					16h K	ind of Busines	
21215-0036	within 72 ine. ihan "na e Madic	Completed	(Specify of Elementary/Secondary	nly highest g	rade completed) College (1-4or 5+)	(Give	kind of work DO NOT use giste	done d retired)	luring mosi)		ng	10b. K		,
	filed v Hygie other t	e Co	12 17. Father's Name (First	, Middle, La:	st)	3	I.e.	JISCE	160			(First, Middle,	Maiden		sing
Maryland	12 should be filed within " h and Mental Hygiene. 7 is marked other than " reaumatic evant, the Mes	To Be	Wiley C. 19a. Informant's Name/	Deletionship	(Time Dains)		105 11-18-		24	Anr		C. Fr		- III av.	
	and 2 st salth and n 27 ts r		Sarah Kou			er								r Town, State, Mary1	and 20816
Baltimore,	of Health of Health liam 27 i		20a. Method of Dispositi		V Damoual from		Place of Dispo cemetery, cren	sition (Name	of er place			ate	20c. Lo	ocation - City o	r Town, State
timo	Pages Iment of h tant: If its jury or of		`4 ☐ Donation 5 ☐	Other (Spec	ify)	>5	lbaugh			L		12005	Uni	lontow	n, PA
Bal	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License-Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore MD 21230												
			23a. Part1. Enter the dis shock, or heart fail	sease, or cor ure. List onl	mplications that of	aused the deat									Approximate Interval Between
	Physician /Medical		Immediate Cause (Fina disease or condition resulting in death)	9	aIc	liopath	nic Pu	11mon	ary	Fib	ros	is			Onset and Death 7 years
	Examiner					(or as a conseq	uence of):								-
	P #	ner	Sequentially list condition if any, leading to immed cause. Enter Underlying	iate	b. Due to	(or as a conseq	uence of):								
	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		c. Due to	or as a conseq	uence of);								
8760,	e be e sician e buris	dical		- (d.	·									
9	ntificat ng phy s as th	Medi	IF FEMALE:												
.O. Box	at the death certific by the ettending prached for use as	Physician/Me	23b. Was decedent pregin the past 12 month	ths?	1 Live b	come of pregna inth 2 Fetal ant at time of do own	Ideath 3□	Ectopic preg Other (spec						23d. Date of de Month	livery Day Year
4	as this gned be de	by Ph	Part II. Other significant	conditions	contributing to d	ath but not resi	ulting in the ur	derlying cau	se givei	n in Part I.					o the cause of death?
ord	w require been si should I	eted											/es 2		robably 🛨 📆 Unknown
Il Records,		Completed												24b. Were a prior to death?	utopsy findings available completion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to examiner?) medical	Hospital:				Cthe	r		(Check only o			
of		n: To	1 ☐ Yes 2 ★ ↑ 27. Manner of Death		28a. Date	of Injury	28b. Time of		. Injury	at Nu	-	ne 5 🗌 Resid		6 □Other (Spe y occurred	ecify)
ion	Attanding I death. ctor: After y the funer	atio	2 Accident	Pending investigation	on	h, Day Year)	Injury	М	Work′ 1 □ Y	es 2 🗆 l	10				
Division	Hospital or Attanding 14 hours after death. Funeral Director: After tely filled in by the fune	Certification;	3 ☐ Suicide 6 [4 ☐ Homicide	Could not determined	d 28e. Place	of Injury - At ho ng, etc. (Specif)	ome, farm, stre	eet, factory, o	ffice		2	8f. Location (5 City or Tox			ural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	Medical (29a. Certifier 1 X (Check only one)	Certifying P Medicel Exa	hysician: To the band man	best of my kno asis of examinat ner stated.	wledge, death tion and/or inv	occurred at estigation, in	the time my opi	e, date and inion, deat	d place, a	nd due to the o	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the I within 2. To the I complet	Me	29b. Signature and title of	of certifier						number	1		29d. Dat	e signed (Mon	
	6			VA		/	M		ש)ע	5868	Т			1/2	20/2005
	9		/ /	ander	completed caus				n+ -	ist '	Hoer	1+21	Gai	thers	ourg MD
	Sta		31. Date filed (Month, Da	JAN'2	1 2005 h	egister's Signa	ture	A. V.		. IS U	เนอะโ	, Lual,			~ T A 11D
	Registr	ar		PINIS W	~ C000	AND SAS.	at the same	A STATE OF THE PARTY OF THE PAR	E. A.						

		•	1 - For State Registrar	State of Maryland / [Department of Health and N Certificate of Death		ene2 0 0 5	01380
	Discontinu		1. Decedent's Name (First, Middle, La			2. Date of Death Month	Day Yeer	3. Time of Death
1	Physicia /Medic		Louisz	Anna KiBL	R	JANUAR		1:12 BW.
	Examin		4a. Facility Name (If not institution, gir		4b. City, Town, or Location of Death	1	4c. County of Death	
			3 snithery2	Ar R25	WHITE HALL	7	HARFOR	Ω
	Funeral			Sex 7. Age (In yrs. last bir	Months Days Hours Min.	(Month, Day, Y	ear) 9. Birthpl	ace (State or Foreign
	Director		219 18 4199	10 M 20 F 80	Yrs.	DIC 12 1	134 Was	Mano
	pu >		Usual Residence of Decedent	10c. City, Tow	n or Location	- '	11	Od. Inside City Limits
	aryla	_	10a. State 10b. County		n or Location			1 ☐ Yes 2 ⅓ No
	n the Maryland r 28a-f show	Directo	CARILORO HARFO	RO FOR				
	or 2	Oire	10e. Street and Number	000	10f. Zip Code	10g	. Citizen of What Coun	try?
	daath with the Maryland ms 23a or 28a-f show rmust be notified at	ai	714 WALTERS	11.17 1900	21050		U.S.A.	
	tar daa Itams	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Salf Yes, specify Cuban, Mexican, Puerl 	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e	
9	afta or It		1 Never Married 2 Married	1 ☐ Yes 25€ No If Yes, Give	1 ☐ Yes 25 No Specify:		Specify:	
5-0036	hours aftar tural', or Ita	d by	3 Widowed 4 □ Divorced	Year or Dates:			HW.	112
ιĊ	n 72 hours aftar daath with "natural", or Itams 23a of dical Examiner must be	Completed	15. Decedent's E (Specify only highest gi		Decedent's Usual Occupation (Give kind of work done during most of work	king 16	b. Kind of Business/Ind	lustry
21	han '	idu	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)		11	
21	a filed withir Il Hygiana. othar than vant, the M	S	137RS		HomeMAKIR	- 15: A 6: H - A 6:	17 HO	W
nd	d oth	Be	17. Father's Name (First, Middle, Las	(1)	18. Mother's Nan	ne (First, Middle, Ma.	iden Sumame)	
<u>la</u>	Mantal Marked carked cattle eva	၉	27251 C 1	JAVIS	MEARL		CHASTER	
Maryland	s 1 and 2 should ba filed within f Haalth and Mantal Hygiana. Itam 27 is marked othar than othar traumatic evant, the Ma		19a. Informant's Name/Relationship	(Type, Print) 19b	. Mailing Address (Street and Number or Ru	iral Route Number, C	city or Town, State, Zip	Code) 21050
	and alth		SANORA HALL	7.	14 WALTERS (list 10	DAO FOR	22 H.IT 6,6	CARLYS
re	of Haa		20a. Method of Disposition	20b. Place o cemete	f Disposition (Name of ny, crematory or other place)	Date 20	c. Location - City or To	wn, State
Ĕ	Page lant c nt: If ry or		1 ☐ Burial 2 ☆ Cremation 3 (`4 ☐ Qonation 5 ☐ Other (Spec	THEMOVAL From State EVACS	EMARSTOF BITHING	005 Fo	11.H. T. 25.	malkage
Baltimore,	permit. Pagas Departmant of Important: If I any injury or once.		21. Signature of Euneral Service Lice	ensee	00.41 14.11 -4.5535		15, A. P. 152	9. 210co
ä			I TOR YOUR		3 NEW PORT ORIV		HIL MAR	11 600
			23a. Part1. Enter the disease, or cor	inplications that caused the death. Do	not enter the mode of dying, such as cardiac			Approximate
			shock, or heart failure. List only Immediate Cause (Final	y one gause on each line.	75716			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. HYTER	I ENSION			
	Examiner			Due to (or as a consequence				
		_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence	00.			
/	ad isit	ine	cause. Enter Underlying Cause (Disease or injury	550 10 (01 40 4 5011004501100	<i>-</i> ,-			
	and and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence	of):			
50,	ba axacutad iician and burial-transit			200 (0) 20 20 00100000000	0.7.			
87	icata ba ay physician tha buria	dicai	•	d				
9	death cartificata e attanding phys d for usa as tha	(a)	IF FEMALE:					
Вох	ath ca ttand or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death			23d. Date of delive Month	ry Day Year
	a dea he at	sici	1 □ Yes 27 No	4☐Pregnant at time of death 9☐Unknown	5 Other (specify)			
P.0	that the de lad by the datached	Physician/M	9 Unknown					
	Tha law raquiras that the ta has been signad by thi vaga 2 should ba datache	by	Part II. Other significent conditions	contributing to death but not resulting i	n the underlying cause given in Part I.		cco use contribute to th	
D	w raquira been si should b	ed				1 🗆 Yes	25 No 3 ☐ Proba	ably 4 □Unknown
S	s been s been s should	Completed				24a. Was an autopsy	24b. Were autop	psy findings available
æ	Tha lav ata has paga 2	mo				performe	d? death?	2 No
Vital Records,		e C	25. Was case referred to medical		26. Place of Dea	ath (Check only one)	110	23.10
5	Phyaiclan: this cartificated rail diractor,	To B	examiner? 1 Tes 25 No	Hospital: 1 Inpatient 2 ER/O	Other		ce 6 Other (Specify	/)
of			27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injury at	28d. Describe how		,
o	ding F th. Aftar funar	tion	1 Natural 5 Pending 2 Accident investigati		Injury Work? M 1 ☐ Yes 2 ☐ No			
Division	Attanding r death.	Certification:	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury - At home, fa	arm, street, factory, office	28f. Location (Stree	et and Number or Rura	l Route Number,
Š	or A aftar Dire	erti	4 Homicide	building, etc. (Specify)		City or Town, S	State)	
_	Hospital		29a. Certifier TS Certifying F	Physician: To the best of my knowledge	e, death occurred at the time, date and place	and due to the caus	se(s) and manner as st	ated.
	Hos 24 hc Fun staly	edicai	(Check only 2 Medical Ext	aminer: On the basis of examination ar and manner stated.	nd/or investigation, in my opinion, death occu	irred at the time, date	and place, and due to	the cause(s)
	To the Hospital or Attandi within 24 hours aftar death. To tha Funeral Director: A complataly fillad in by tha fu	Mec	29b. Signature and title of Certifier	And marrier stated.	29c. License number	29d	. Date signed (Month, L	Day, Year)
\	18787		DO V A/V	Rm Inn	1726841		-	
	17		my HI	1 WILL	11/20014)	ANVARY 19	1,3005
	•		30. Name and address of person who	completed dause of death (Item 23a)	(Type, Print) HRAVENBINDSHITE 2	MA Rala	maren	21239
			2200 4411 6 22 11 11			07//	MILLANCE AUT]	2177
	Sta Registi		31. Date filed (Month, Day, Year)	32. Reflistrar's Signature	parte			

			ricase	State of N							ental Hvo	iene	egibie.	
		•	1 - State	State of I	iaiyiaii	-			Death			Reg. No	005	01381
			Registrar 1. Decedent's Name (First, Middle, Las	t)			.,,,,,		- Julia		2. Date of Dea	ith		3. Time of Death
	Physici		Lillian B. Kre	he							January	Day 17,	2005	8:00 P M
	/Medic Examin		4e. Facility Name (If not institution, give		r)		4b. Cit	, Town, or	r Location o	of Death		4c. C	ounty of Death	
			Greater Baltimore					son					ltimore	
	Funeral		5. Social Security Number 6. Se	ox 7.7 ⊐M. 2√□X F	ge (In yrs. 93	last birthdey) Yrs.	Month:	or 1 Year Days	If Under :	Min.	8. Date of Birth (Month, Day	, Year)		place (Stete or Foreign ntry)
	Director		216-09-3763 " Usuel Residence of Decedent		93		1				7-18-	1911	Mary	yland
	yland how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	e Marfe	ctor	MD Baltimo	re	G	len A	rm							1 ☐ Yes 2 ☐ No
	vith th	Director	10e. Street and Number		•			ip Code					on of What Cou	ntry?
	88th v	Funerai	11630 Glen Arm	Rd #G1 12. Was Deceder		S 13.3		LO57	lispanic Orio	gin? (Spe	city Yes or No-	US.	A I. Race - Ameri	can Indian.
10	fter d ritarr	Fun	1 Never Married 2 Married	Armed Forces 1 Yes 2 If Yes, Give	?		-			, Puerto I	cify Yes or No- Rican, etc.)		Black, White,	etc.
93	rai', o	l by	3 Widowed 4 □ Divorced	If Yes, Give ² Year or Dates	:		1 L Yes	X□ No	Specify:			S	pecify: Wh	nite
5-0	within 72 hours after deeth with the Maryland ene. Than "natural", or Itams 23e or 28e-f ehow he Mudical Exertime mast be mulified at	Completed by	15. Decedent's Ed (Specify only highest grad	ucation de com <i>pleted)</i>		16a. Dece (Give	kind of v	ual Occup rork done d use retired	during most	t of workit	ng	16b. Kind	d of Business/Ir	ndustry
12	within Bne. than	duic	Elementary/Secondary (0-12)	College (1-40	r 5+)			a1 E:					2+2+0	of MD.
2 2	itled wi Hygien other th	Be Co	12 17. Father's Name (First, Middle, Last)			rer	SOII			er's Name	(First, Middle,			01 190.
ılan	Mental Merked o		Henry Bauman						Ma	ary	Eliza	oeth	Kistr	er
Maryland 21215-0036	and is m		19a. Informant's Name/Relationship (7			1	37.				Route Numbe			
	1 and Health em 27 other tr		Marilyn Carr/ D 20a. Method of Disposition	augnter		310 Place of Dispo		ore:	s Rd		1dwin,		ZIUI3 ation - City or T	
nor	Pages nent of h int: If ite		XXBurial 2 Cremation 3	Removal from Stat	e C	emetery, crei	matory of	other plac	(6)		~2005		ltimor	
Baltimore,			*4 □ Donation 5 □ Other (Specify 21. Sign = va of Funeral Fervice Licen		HO	ly Re	aeei 2. Name	ner and Addre	ss of Facilit					emories
B	permit. Departr importu		MATTE	MO	1220					•				21234
	O EU		23a. Part1. Enter the disease, or companies, or heart failure. List only	olications that caus	ed the deat line.	h. Do not ent	ter the m	ode of dyin	ng, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. /n	eun	Ania								Onset and Death
78	/Medical Examiner		resulting in death)	Due to or a	s a conseq	uence of):	1							1
3		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or	is a conseq	uerige of):								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,										
oʻ	ate be executed hysician and he burial-transit		resulting in death) Last	Due to (or a	s a conseq	uence of):								
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x 68	that the death certificat led by the attending phy detached for use as th	/Med	IF FEMALE:	23c. If yes, outcon	e of preon:	ancv						22	Id. Date of deliv	0.01
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	6		30. Name and address of person who	completed cause o	f death (Iter	n 23a) (Туре.	Print)	inni	راد ال	1	BHLT/1	and a	5 111/	21204
	(-		31. Date filed (Month, Day, Year)	JAN C	strar's Signa	[U] /	IV Or	MILL	7 9		7141/1		, 021()	01007
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registramend ITEM #2 PER DES C839 1/299 difficate of Death Reg. No.-2. Date of Death **2005** 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 1221 AZAL d AA /Medical 4c. County of Deeth **Examiner** 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death wers ville Sudley ARWOOD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 12 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year XXM 2 F 68 Yrs N/A 1936 Director Indonesia Usual Residence of Decedent death with the Maryland 10a. State New 10c. City, Town or Location 10d. Inside City Limits 10b. County Show or than "neturel", or items 23a or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director North Ryde So.Wales N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2113 114 Twin Road Australia Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onen of Health and Mental Hyglene.
Interference of the Them and The marked other than "neturel", or Itele and yor other treumatic svent, Itele Madical Examinatory or other treumatic svent, Itele Madical Examinating. 1 Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ¾ No Specify: Be Completed by Specify: Asian 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Architect Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pang Nio In Tee Bie ဥ The 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Anderson (Daughter) 4561 Owensville-Sudley Road, Harwood, MD 20776 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 ACremation 3 Removal from State permit. Page Department of Important: If any injury or once. Metro Crematory ^¹ 4 □ Donation 5 □ Other (Specify) 01/19/2005 Baltimore, MD 22. Name and Address of Facility
Hardesty Funeral Home P.A.
12 Ridgely Avenue, Annapolis, 21. Signature of Funeral Service Licensee alson Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause at each line. Immediate Cause (Final disease or condition resulting in death) **Physician** rteriosclerotic /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Examiner physician and the burial-transit or Attending Physician: The faw requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 XNo 3 ☐ Probably 4 ☐ Unknown been significant 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 2 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes director, DAUGHTON'S 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) funeral Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Division 1 Natural 2 ☐ Accident 5 Pending To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier puty

Registrar

DHMH 17 Rev 1/2001

State

who completed cause of death (Item 23a) (Type, Print)

ONES, MD

32 Registrar's Signature

2005

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or 2		10e. Street and Number			10f. Zip Code		16	0g. Citizen of \	What Cour	ntry?
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ai di di	Be	17. Father's Name (First, Middle, Last)	_			18. Mother's Name				
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27 Is ma		19a. Informant's Name/Relationship (Ty.) Rose Marie Kirby			•	and Number or Rura ${ t icholson}$ V				
tem		20a. Method of Disposition	I.	20b. Place of Dispo cemetery, crea	osition (Name of matory or other plan		Date	20c. Location	City or To	own, State
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				1 - State of Mar Registrar			lealth and M	lental Hygid	•	0/385
		Physici /Medio		1. Decedent's Name (First, Middle, Last) THEODORE STANLEY KUCHA	ARSKI			2. Date of Death Month JANUARY	Day 2005	3. Time of Death 3:00 PM
		Examir		4a. Facility Name (If not institution, give street and number) 2900 UNIONTOWN ROAD		WESTMI			4c. County of Dea	1
		Funeral Director		5. Social Security Number 6. Sex 7. Age ((In yrs. last birthday) 80 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1 SEPTEMBE	^(ear) 22, 1924	thplace (State or Foreign ountry) MARYLAND
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, ,		with the N a or 28a-i	Direct	10e. Street and Number 2900 UNIONTOWN ROAD		10f. Zip Code 2115	58		p. Citizen of What Co	ountry?
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ال	Maryland 2	2 should be filed withir and Mental Hygiene. is markad other than aumatic evant, the Mis	To Be C	17. Father's Name (First, Middle, Last) JAMES KUCHARSKI			18. Mother's Name	e (First, Middle, Ma BIRDICK	iden Sumame)	
EODORE		s 1 and 2 should f Health and Men itam 27 is marks other traumatic		19a. Informant's Name/Relationship (Type, Print) RITA B. KUCHARSKI/WIFE		ng Address (Street a		I Route Number, (IESTMINST	ER, MD 2	Zip Code) 1158
1 9	altimore,	permit. Pages 1 and 2 Depertment of Health a Important: If itsm 27 is any injury or other tree		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		osition (Name of matory or other place CREMATION	(e)		oc. Location - City or AMPSTEAD,	
=	Balt	permit. Depertrimports any inju		21. Signature of Funeral Service Licensee		2. Name and Address YERS-DURE		RAL HOME	, P.A.	21157
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	ion of	tending Physician: The leath. tor: After this certificate ha the funeral director, page	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident 1 Inpatient 28a. Date of Injury (Month, Day)		1 28c. Injun	4 Nuising Ho	28d. Describe how	ce 6 ☐ Other (Sperinjury occurred	спу)
	Division	ai or Atte s after de si Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	y - At home, farm, str (Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ural Route Number,
		To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical (29a. Certifier 1 ☐ Certifying Physician: To the best of (Check only one) 2 ☐ Medical Exeminer: On the basis of e and manner state	xamination and/or in					
)	X	Me	29b. Signature and title of contriber	ame	29c. License	a number 2000	290	Date signed (Mont	h, Day, Year)
		10,			700A POOLE		VESTMINSTE	ER, MD 2	1157	
		Sta Registi		31. Date filed (Month Pay, Year) 2005 32. Mgistrar	s Signature	4				

			- FOI	State of Marylan	d / Depa	artment of	Health an		giene	01200
			1 - State Registrar		Cer	tificate of	Death		Reg. No.	01386
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Year	3. Time of Death
	/Medic	al	Donald W. Kalkman			41. Ch. T		Januar	y 14, 2005 4c. County of Deat	17:06 P M
	Examir	er	4a. Facility Name (If not institution, give st Manor Care Dulane			Towson	or Location of D	eatri	Baltimon	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. i	ast birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Bir		hplace (State or Foreign untry)
	Funeral Director			M 2□F 89		Months Days	Hours A	Ain. <i>(Month, Da</i>	y, Year) Co er 1,1915 Ma	untry) arvland
	P .		Usual Residence of Decedent	140.00						
	arylau	<u>.</u>	10a. State 10b. County		, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	Ne M	Director	Maryland Baltimor 10e. Street and Number	e Ti	monium.	1 10f. Zip Code			10g. Citizen of What Co	
	with with	Dir	203 Charmuth Road			2109	3		United Sta	
	ns 23	Funeral		2. Was Decedent Ever in U.	S. 13. V			? (Specify Yes or No uerto Rican, etc.)		ricen Indian,
٥	or Her of	Fun	1 Never Married 2 Married	Armed Forces? 1⊠Yes 2□No				uerto Rican, etc.)		e, etc.
5	hours after death with the Maryland turel; or Items 23e or 28e-f show at Exact at must be notified at	1 by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I∐Yes 2⊠ No	э Брөспу:		Specify: Whi	te
7	be filed within 72 hours after death with the Marylar dat Hygiene. I all Hygiene. I the Wedlest Enaction of the provided at the confiled at event, the Medlest Enaction of the confiled at	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Deced (Give	lent's Usual Occu kind of work done DO NOT use retire	pation during most of	working	16b. Kind of Business/	Industry
7	within then then	du	Elementary/Secondary (0-12)	College (1-4or 5+)		ty Manag			Enginosui	
0	filed within 72 Hygiene. other than "ne ent, the Medic	CO	17. Father's Name (First, Middle, Last)		Quali	Ly Hallas	4	Name (First, Middle,	Engineeri Maiden Sumame)	.ng
a		To Be	C.W. Kalkman				Clar	a D. Hoff	man	
Maryland 21215-0036	2 should and Mer is marks eumatic	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Stree	t and Number of	r Rural Route Numbe	er, City or Town, State, Z	Tip Code)
	s 1 and 2 should f Health and Mer item 27 is marke other treumatic		Donald W. Kalkman					son, MD 2	1204	
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Re			sition (Name of natory or other pla		Date	20c. Location - City or	
Ĕ	Pages Iment of I tent: If it		`4 □ Donation 5 □ Other (Specify)	ват				-	5 Laurel, M	
Baltimore,	permit. Pages 1 Department of H Importent: If Ite any Injury or of ence.		21. Signature of Funeral Service Licensed	900	22 B	Name and Addr	ess of Facility Ashton–M	latthews F	uneral Home	, Inc.
	auz e a		23a. Part1. Enter the disease, or complic	relicions that caused the death	Mone	> 2134	Willow	Spring Rd	Baltimore,	MD 21222
			shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.	· ·			olac of respiratory at	1031,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequ		OPATH	17			
	Examiner			Due to for as a consequ	ence or).					
		ner	Sequentially list conditions, if any, leading to introducts cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ianea ut):					
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/bg/	be executed ician and burial-transit	Ě	resulting in death) Last	Due to (or as a consequ	ence of):					
789	e y e	dicai	d.							
×	certif iding ise a	Physician/Med	IF FEMALE: 23	c. If yes, outcome of pregnar	ncy				23d. Date of deli	VARV
POX	the death y the atter iched for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetel 4 ☐ Pregnant at time of de	death 3 🗌	Ectopic pregnand Other (specify)	y		Month	Day Year
j.		hysi	9 Unknown	9□ Unknown						
r.	w requires that been signed b should be deta	by P	Part II. Other significant conditions conti		Iting in the un	iderlying cause gi	ven in Part I.		bacco use contribute to	-
coras	equire en sig	ted	PROSTATE C	LANCER				- 101	res 2□No 3⊡Pro	bably 4 Unknown
ပ္		ompleted						24a. Was	sy prior to c	topsy findings available ompletion of cause of
	sicien: The law s certificate has t lirector, page 2 s	Cou						perfo	med? death? 2 ☑ No 1 ☐ Yes	2 🗆 No
Vital	Physician: this certific al director,	Be	25. Was case referred to medical examiner?	ospital:			hor	Death (Check only o		
5	£ 1 1 1	. To	1 ☐ Yes 2 ☑ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 Inpatient 2 L	ER/Outpatient 28b. Time of	3L DOA	4 (SHRuisin		ence 6 Other (Spec	ify)
UO	ding th. After	tion	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Inju Wo M 1	rk?]Yes 2 □ No		,,	
DIVISION	Atten r dea ector by the	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho.	me, farm, stre	et, factory, office		28f. Location (S	Street and Number or Ru	ral Route Number,
5	tel or s afte el Dir	Certification:	4 Homicide	building, etc. (Specify) 			City or Ton	m, State)	
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funerel	- 20	(Check only 2 Medical Examine	cian: To the best of my knower: On the basis of examinat	vledge, death	occurred at the t	me, date and pla	ace, and due to the o	cause(s) and manner as date and place, and due	stated. to the cause(s)
	thin 2 the or the	Medic	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number	1	29d. Date signed (Month	Dav. Year)
	F 3 F 8		L A M	D					/	
	,2	1	30. Name and address of person who com		23a) (Type F	Print)	2600	LIRSRAV	1(18/05 HE14M75	MENIES
	10					2 GROWA	BA	LIMORE	MD 2121	5
N.	⊚ Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure .	1 .				
	Registr	ar	JAN Z 1 21	UUS Clasur	J. A	gosele				İ

			For State	State of Mary		partment of F			2005	01007
			Registrar 1. Decedent's Name (First, Middle, L	ast)		si iiiicate oi		2. Date of Death		3. Time of Death
	Physicia /Medic		Juseph C	Lee JK				Month War	4 17,200S	454 M
	Examin	100	4a. Facility Name (If not institution, ga			-	or Location of Death		4c. County of Deat	h
	Summer		MERCY HUSPI 5. Social Security Number 6.		yrs. last birthda	BA I from		8. Date of Birth	9. Birt	nplace (State or Foreign
	Funeral Director		227 48 2836	12M 2□F 65	Yrs.	Months Days	Hours Min.	Month, Day,	Year) Co	V. A.
and	*	ĺ	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or	Location				10d. Inside City Limits
Магуl	of sho	tor	M.D NIC	2	BAIT	mare				1 of es 2 □ No
th the	or 288 s noti	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	untry?
ath w	s 23g	rai		12. Was Decedent Ever	E f	2122		it. Yes or No	U.S.A. 14. Race - Ame	rican Indian
fter de	i, or items 23s or 28s-f show cardiner must be nutified at	Funerai	11. Marital Status 1 Never Married 2 Married	Armed Forces?	rin 0.5.		Hispanic Origin? (Spec lan, Mexican, Puerto P	lican, etc.)	Black, White	
-0036 hours after death with the Maryland	neturel', o	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 € No	Specify:		Specify: B1	acle
	0 0	Completed	15. Decedent's (Specify only highest g	rade completed)	(Gi	edent's Usual Occup re kind of work done . DO NOT use retire	during most of workin	g 1	6b, Kind of Business/	industry
36 ph d 21215-	r thar	mo:	Elementary/Secondary (0-12)	College (1-4or 5+)		SECURITY	Africe		SECURT	1
SS	Mental Hygiene arked other than atic event, the	Be C	17. Father's Name (First, Middle, Las	st)			18. Mother's Name		•	
Maryland	and Mental Hygiene. Is marked other than eumatic event, tre Mi	ြ	JUSEPH LEE 19a. Informant's Name/Relationship	(Type Print)	19h Ma	ilina Address /Street	ANER and Number or Rural	BAK.		(in Code)
, Ma			VERGIE Snowden			Monker	DOVER DE			,p code,
9 o e	of Health fitem 27 r other tr		20a. Method of Disposition 1 Surial 2 Cremation 3	2	20b. Place of Dis	position (Name of rematory or other pla	Ce)	ate 2	0c. Location - City or	
altimore	Department Important: I eny injury o once.		`4 □Donation 5 □Other (Spec	cify)	ARbufu	s memaria	ess of Facility B	115	BALtimons	MD
Balt Bernit.	Depar Impor eny in		21. Signature of Funeral Service Lic	ensee				_		
	, ÿ.		23a. Part1. Enter the disease, or co	mplications that ceused the			ng, such as cardiac or			Approximate Interval Between
Pt	nysician		shock, or heart failure. List onl Immediate Cause (Final disease or condition	y one cause on each line.	1.	in can				Onset and Death
	Medical xaminer		resulting in death)	Due to (or as a co	onsequence of):	3				
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence of):					
uted	id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.						
760,	sician and burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):					
3876 icate b	physic s the b	dicai		d	-					
ox 6	attending phy I for use as th	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐		DEstania programa			23d. Date of deli	very
I Records, P.O. Box 68760, The law requires that the death certificate be executed	the atte	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time 9□Unknown		B Ectopic pregnanc Other (specify) _			Month	Day Year
P.C	igned by the be detached		Part II. Other significant conditions	contributing to death but no	ot resulting in the	underlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds,	n sign	ed by						17 Yes	3	obably 4 Unknown
OCO Daw rec	as been si 2 should	Completed						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
The The	page	Com						perform	ed? death? ☑ No 1 ☐ Yes	2□ No
Vita	s certificate has E lirector, page 2 s	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ☐ ER/Outpat	ent 30 DOA Ott	26. Place of Death			
of Of	h. After this certificate ha funeral director, page	-	27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	-	of 28c. Injur	4 Nursing Hon	Bd. Describe how		nospice
Sion	death. ctor: After y the funera	atlo	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	ion	sal/ Injury		Yes 2□No			
Division of Vital Records,	Direct Direct in by	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Injury - building, etc. (S	- At home, farm, Specify)	street, factory, office	2	8f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
Division of Vita	within 24 hours after death To the Funeral Director: completely filled in by the			Physician: To the best of m						
å H	the 54	Medical	опе)	aminer: On the basis of exa and manner stated.	amination and/or					
۵	To	~	29b. Signature and title of certifier			29c. Licens) 40 8 5 9	29	d. Date signed (Month	VOO≤
	1		30. Name and address of person wh	o completed cause of death	ı (Item 23a) (Typ	-	, , , , ,			
. W	W		David, Risuber	mg 301 5T	Paul 1	Pi Balti	more ma	1. 212	56	
(Sta Registr		31. Date filed (Month, Day, Year) JAN 2 1	32. Agistrar's	Signature	f. n.				
6				-000 F3 (AS)	15- 1	MISALE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#5.10b.d.perFH.G839.1/24/05 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) L APLANTE Month Day **Physician** ATRICIA 0856 M ANYARY 20 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAITIMIRE NORTHWEST RANDALISTONN HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 7 1936 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 💢 F 68 235-58-2765 Director Usual Residence of Decedent with the Maryland 10c City Town or Location 10a State 10h Counts 10d. Inside City Limits 28e-f show 7 is marked other then "natural; or items 23a or 28e-f show treumatic event, the Medical Expert set must be untilled at MA Westfield 1X Yes 2 □No Director Hampden 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 508 Granville Road 01085 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

10 Yes 2 No 196014 Yes, Give Year or Dates: 1962 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 "natural", or Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. health care nurse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) parmit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any linjury or other treumatic event 9DRS. Be Hazen Monroe Craven Gwendolvn 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter A. LaPlante (spouse) 508 Granville Rd., Westfield, MA 01085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation | 1-21-05 Sykesville, Md * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Maigrapaight Herbert P.O. Box 195 Sykesville, Md 21784 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1. Enter the disease, or complications that causshock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death Immediate Cause (Final ASTATIC **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, immagisted cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Denknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy rmed? 253 No this certificate Yes or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Department 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Zeath 28b. Time of 28d. Describe how injury occurred After 1 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20,2005 JANY ARY 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) MO 21133 MP, NHC, JAITO 2. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar 1 2005

			1 = For State Registrar	State of I	Maryland /		artment o			ind Me		giene	005	0138	39
F	Physici	an	1. Decedent's Name (First, Middle							2	2. Date of Dea Month	Day	Year	3. Time of De	
	/Medic	al	Harriette	A.		ehne			Location	4 Dooth	Januar		2005	10:15	a ^M
F-	Examin	er	4a. Facility Name (If not institution Crofton Conva.				4b. City, To		ofton				inne Ar		
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last b	irthday)	If Under 1	Year	If Under 2	24 Hrs. 8	B. Date of Birth	h	9. Birth	place (State or F	oreign
	Director		212-07-7450	1 □ M 2/QXF	86	Yrs.	Months D	Days	Hours	Min.	(Month, Day			yland	
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	wn or Lo	cation			~			1	10d. Inside City I	Limits
	Mary 1 sho	to	MD Anne	Arundel	Sev	ern								1 □ Yes 2 ∑	Q No
	th the	lirec	10e. Street and Number				10f. Zip Co	ode				10g. Citizer	of What Co	intry?	
	ath wi	raic	8090 Telegrap					211					USA		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: if Item 27 is marked other then "natural", or Items 23a or 28a-f show entry injury or other treumatic event. Its Medical Exam har must be notified at ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☒ Widowed 4 ☐ Divorced	If Yes Give	ss? XXNo		Was Deceden If Yes, specify 1 ☐ Yes 2 ☑		spanic Orig n, Mexican, Specify:	gin? (Spec , Puerto Ri	ify Yes or No- ican, etc.)		Race - Amer Black, White pecify:		
Maryland 21215-0036	72 ho naturi	Completed	15. Deceder	t's Education st grade completed)	168	a. Dece	dent's Usual (Occupa done di	tion uring most	of working	7	16b. Kind	of Business/l	ndustry	
2	vithin ne. hen "	mple	Elementary/Secondary (0-12)	College (1-4			kind of work of DO NOT use	retired)				•			
2	filed v Hygie Ither t	CO	12 17. Father's Name (First, Middle,	Last)	Н	omer	naker		18. Mother	r's Name (First, Middle,		Home		
a	lid be lental ked c	To Be	William Sears						Ruth	Verm	illion				
ary	and N and N s mai		19a. Informant's Name/Relations			b. Maili	ng Address (S	Street a			Route Numbe	r, City or To	own, State, Z	ip Code)	
	and 2 ealth m 27		Michelle Lehne	er (Daughte	-	77,007			h Roa		evern,				
Baltimore,	iges 1 nt of H : If Itel or otl		20a. Method of Disposition 1 Burial 2 Cremation		ate cemet	ery, crei	natory or other	er place	·	Da			ion - City or		
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Ba	Depa Impo eny ii		V Batal A	MA			Hardes	sty leel	Funei V Ave	ral H enue.	ome, P Annap	.A. olis.	MD 21	401	
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89 x	uires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy							23d	. Date of delir	/erv	
Box	death e atter d for u	Iciar	in the past 12 months?	4☐ Pregnan	n 2 ☐ Fetal deat t at time of death		∃Ectopic preg ∃Other (spec						Month	Day Yea	ır
P.O.	The law requires that the ate has been signed by the page 2 should be detache	hys	9 ☐ Unknown	9□ Unknow				-		-	1				
	res th iigned be de	b	Part II. Other significant conditi	ons contributing to deat	h but not resulting	in the u	nderlying cau	se give	n in Part I.		1		contribute to	the cause of deat	
Records,	w requir been si should I	Completed								-		1			
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<u>e</u>	Physicien: The lav this certificate has ral director, page 2	e Co	25. Was case referred to medica	1					26 Place	of Death (1 ☐ Yes 'Check only or	2No	1 ☐ Yes	2□ No	
Ž	Physicien: r this certifica ral director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inp	atient 2 ER/C	Outpatier	nt 3 DOA	Dthe			e 5 ☐ Resid		Other (Spec	ıfy)	
Division of Vital	Attending Phir death. ector: After thiby the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investi	gation	njury 28b. <i>Day Year)</i>	Time o Injury	f 28c	. Injury Work 1 🗆 Y	at ? ∕es 2 □ N		d. Describe h	ow injury o	ccurred		
DIX	i ji te	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 288. Place or building	Injury - At home, , etc. (Specify)						City or Tow	m, State)		ral Route Number	r,
	To the Hospitel within 24 hours a To the Funeral C completely filled	Medical		ng Physician: To the be Examiner: On the basi and manner	s of examination a										
	o the	Med	29b. Signature and title of certifie		Statos.		29c. L	icense	number			29d. Date s	igned (Month	, Day, Year)	
	->-0						7) =	מרי	28		} -	14-0	5	
	1		30. Name and address of person	who completed cause	of death (Item 23a) (Туре,	Print)								•
	2		ADITYA CH	DPRAM	M.D. W	OC	Rida	jel	4 A	ve.5	ste. 23	1 An	nayo	5 is, nid. 2	21401
	Sta Registi		31. Date filed (Month, Day, Year)	2005	istrar's Signature		<u> </u>)							
DH	MH 17 Rev 1/2	- (1)		COUL COUL	w K	4h	W)								
					OR	IGIN/	AL.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005

Kri	5	•	1 - State Amend Item Registrar	1&Unpend It	em 23a	a,27°	28a-f per	me G840 Death	'Z-'8-'05' 4	tas	0 01390
	a Discosio		1. Decedent's Name (First, Middle, I						2. Date of Deat Month	h	3. Time of Death
	Physici /Medio			helle		Pinto			January	$14^{\text{Day}}, 2005^{\text{Year}}$	0830 P M
7	Examin		4a. Facility Name (If not institution, g					Location of Death		4c. County of Dea	
			1647 Cananaro Dr: 5. Social Security Number 6		ge (In yrs. las	t hirthday)	Annapol	.1S	9 Date of Birth	Anne Arun	
967	Funeral Director		220-69-1328 Usual Residence of Decedent	1 M 2 X F	je (iii yis. ias	Yrs.	Months Days 5 26	Hours Min.	8. Date of Birth (Month, Day, July 19		thplace (State or Foreign ountry) yland
~	land ow		10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits
	the Marylar 28a-f show	ţō	MD Anne A	rundel	Anna	apoli	s				1 ☐ Yes 2X No
	th the	irec	10e. Street and Number				10f, Zip Code		10	0g. Citizen of What Co	ountry?
	23a (23a ust b	raic	1605 Cananaro C	ourt			2140			USA	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Ilem 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Marical Examiner is ust be notified at	d by Funeral Director	11. Marital Status 1XXNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 200 If Yes, Give Year or Dates:)		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes XXNo	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	
5-0	72 h "natu	Completed	15. Decedent's (Specify only highest)	Education grade completed)		16a. Deced	dent's Usual Occup kind of work done	ation during most of work d)	ing	16b. Kind of Business	/Industry
121	within ane. than	dw	Elementary/Secondary (0-12)	College (1-4or	5+)	N/A	DO NOT use retired	3)		N/A	
d 2	filed with Hygiene other thai	ပိ	17. Father's Name (First, Middle, La	st)		N/A	-	18. Mother's Name	e (First, Middle, N	·	
lan	ld be ental ked c	To Be	Unknown					Denise N	Marie Lo	Pinto	
ary	2 should be f and Mental H Is marked of aumatic eve		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Street	and Number or Run	al Route Number,	City or Town, State,	Zip Code)
Ξ	and 2 valth a n 27 ls er tra		Denise M. LoPin	to (Mother)			Contract Con		Annapoli	s, MD 2140	1
nore	ages 1 ant of He It. If Item y or oth		20a. Method of Disposition XX Burial 2 □ Cremation 3 3 4 □ Donation 5 □ Other (Spe		1		sition (Name of matory or other place	eθ) 1/18/		20c. Location - City or Annapolis,	·
Baltimore,	permit. Pages 1 and 2. Department of Health at Important: If Item 27 Is any injury or other trau	j	21. Signature of Funeral Sovice Lie	Home, P	.A.						
	70 = 4 0		23a. Part1. Enter the disease, or co	amplifications that sauce	d the death	Do not ont	12 Ridge	ly Avenue	Annapo	olis, MD 2	1401 Approximate
	Physician /Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Asphyxia	ine.		er the mode of dyin	ig, such as cardiac (or respiratory arre	951,	Interval Between Onset and Death
	Examiner		1	Due to (or as	a conseque	nce or,					
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as	a conseque	nce of):					
	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	с.							
Ő,	rificate be executed og physician and as the burial-transit	Ä	resulting in death) Last	Due to (or as	a consequer	nce of):					
68760,	cate b physic the b	Medical		d						-	
Вох	The law requires that the death certific Ite has been signed by the attending p bage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	livery Day Year
ds, P.O.	signed by	by	Part II. Other significant conditions	s contributing to death t	out not resulti	ing in the u	nderlying cause give	en in Part I.		acco use contribute to	∠
COL	w require been sign	iete							24a. Was ar	24b. Were au	utopsy findings available
Re	The lav	Completed							autopsy	prior to death?	utopsy findings available completion of cause of
ital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					26. Place of Death	7		
) V	S S	은	XXYes 2□ No	Hospital: 1 ☐ Inpati		NOutpatien		4 Nursing Ho		nce 6 Other (Spe	cify) At Scene
Division of Vital Records,	ing After une	ation:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat	28a. Date of Inju (Month, Da Ion 1-14-05		Bb. Time of Countd 3:20	28c. Injun Work PM 1			w injury occurred ated while	bed
Divis	2 5 5	Certification:	3 Suicide 6 Could not 4 Homicide determine	a 28e. Place of in	jury - At homito. (Specify)	e, farm, str	eet, factory, office		28f. Location (Str City or Town	eet and Number or Bu , State) 1647 Ca s MD	ananaro Dr.
	Hospita 24 hours Funeral tely filled	edical C		Physicien: To the best eminer: On the basis of and manner st	of examination			ne, date and place,	and due to the ca	use(s) and manner as	
	To the within 2 To the comple	Me	29b. Signature and title of certifier	1 = -			29c. License			d. Date signed (Mont	
	> 0		(araf +	Hellan	nd		0.C.N	1.E.	Ja	anuary 15,	2005
			30. Name and address of person wh	no completed cause of	death (Item 2	^{3a) (Type,} Penn	Street,	Baltimore	e, Maryla	and 21201	
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 1 201	32. Registr	rar's Signatur	Gard	v v				

			_ 101	artment of Health and Mental H rtificate of Death	ygiene Reg. N2 0 0 5 0 3 9
	Physici		Decedent's Name (First, Middle, Last) Lydia Lanno	2. Date of E Month January	y 18, 2005 3. Time of Death 4:40 P.M.
	/Medio Examin	er	4a. Facility Name (If not institution, give street and number) Future Care Old Court	4b. City, Town, or Location of Death Randallstown	4c. County of Death Baltimore
	Funeral Director		5. Social Security Number 464-52-7665 G. Sex 1 M 27 F 7. Age (In yrs. last birthday, Yrs.) 1 Vsual Residence of Decedent	Months Days Hours Min. (Month, L	9. Birthplace (State or Foreign Country) er16,1906 Estonia
	e-f show	ctor	10a. State 10b. County 10c. City, Town or L MD Carroll Mt. Air		10d. Inside City Limits 1 □ Yes 2 No
	th with the 23a or 28 ust be not	Funeral Director	10e. Street and Number 5158 Perry Road	10f. Zip Code 21771	10g. Citizen of What Country? United States of Americ
036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "neturel", or items 23a or 28e-f show other treumatic event, the Medical Examinating the mailtied at	by Fune	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Sive Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or Nif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ※XXNo Specify:	No- 14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	withln 72 ho lene. than "netur the Medical	Completed by	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired) \$1ator	16b. Kind of Business/Industry U.S. Government
	should be filed and Mental Hygid s marked other umatic svent, II	To Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Midd aknown Anna Tutt	
	1 and 2 sho Health and I em 27 is me		Eva Mack (Daughter) 5158 20a Method of Disposition 20b. Place of Disp	ing Address (Street and Number or Rural Route Num Perry Road, Mt. Airy, M. position (Name of Date	HD 3447
Baltimore,	permit. Pages Department of I importent: If ite any injury or or once.	l	1 Burial 2XX remation 3 Removal from State 4 Donation 5 Other (Specify) Balt imore-Was 21. Signature of Funeral Service Licensee	2. Name and Address of Facility $\operatorname{Loring}\ \operatorname{By}$	ers Funeral Directors
e E	e G ii ii d		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	,	
1	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	clerosus	
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injusy that initiated events b. Due to (or as a consequence of): cause (Disease or injusy that initiated events c.		
8760,	cate be executed physician and s the burial-transit	edical Ex	resulting in death) Last Due to (or as a consequence of): d.		
P.O. Box 6	death certiff e attending id for use as	Physician/Me		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
	The law requires that the de ate has been signed by the a bage 2 should be detached l	þ	Part II. Other significant conditions contributing to death but not resulting in the Congestive Heart Failure		d tobacco use contribute to the cause of death? ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
Vital Records,		Completed	Hypothyroldism	per	as an topsy findings available prior to completion of cause of death? 1 2 No 1 Yes 2 No
of	ding Physicien: Th n. After this certificate funeral director, pag	To Be	25. Was case referred to medical examiner? 1	of 28c. Injury at Work? 28d. Describe	y one) sidence 6 □Other (Specify) e how injury occurred
Division	or Attsno ifter death Sirector; in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No reel, factory, office 28f. Location City or T	(Street and Number or Rural Route Number, rown, State)
	To the Hospitei or within 24 hours after To the Funeral Discompletely filled in	edical	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, dea 2 Medical Exeminer: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at the time	e, date and place, and due to the cause(s)
	o T with	M	29b. Signature and title of certifier Crisberg Construction of the second death (New 22a) (Time	29c. License number D0020964	29d. Date signed (Month, Day, Year) 1/19/2005
	Sta	ite.	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ty Plaza Mall Randalls	town, MD 21133
DI	Regist	rar	JAN 2 1 2005 Brane &	berte	

			For State Registrar	State of Marylan		artment of Hertificate of E			giene 2005	01392
ı	Discontati		1. Decedent's Name (First, Middle, Las					2. Date of De Month	nath Day Year	3. Time of Death
	Physicia /Medic		Morris	Lipow				Jan	15 2005	1845 M
	Examin		4a. Facility Name (If not institution, give	2.1	1	4b. City, Town, or	A	1	4c. County of Death	
			Holy Cross			211601	70017	9	monteo:	
	Funeral		5. Social Security Number 6. S	TTN OFF		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	5-1910	place (State or Foreign intry)
	Director		425-60-9179 Usual Residence of Decedent	94	4 113.			03-26	0-1910	Poland
	iand wo		10a. State 10b. County	10c. Cit	y, Town or Lo	ecation				10d. Inside City Limits
:	Mary f sh	ţo	MD Silve	r Spring 145	508 Hor	mecrest Ro	1 #410 S	ilver S	pring	1 ☐ Yes 2 ☐ No
	28e	90	10e. Street and Number			10f. Zip Code			10g. Citizen of What Cou	intry?
	3a or	ā	14508 Homecrest	Rd # 410		20906			USA	
	death ms 2	Funeral Director	11. Maritat Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (S	pecify Yes or No	14. Race - Amer Black, White	
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other treumatic event, it a Medical Examiner roust be notified at once.	Ē	1 ☐ Never Married 2 Married	1 ☐ Yes 2 🛣 No	1	1 □ Yes 2 □ No	Specify:	o racan, etc.)		
3	ral', c	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 165 2 X 110	Specify.		Specify. Win	ite
ה ה	72 h	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occupa kind of work done d	uring most of wor	king	16b. Kind of Business/li	ndustry
7	ithin Ne.	du	Elementary/Secondary (0-12)	Coltege (1-4or 5+)		DO NOT use retired)			Small Bu	aineae
7	ygier ygier her th	S	47 E de de Nove (First Middle 1 and	2	Acc	countant	19 Mother's Non	no /First Middle	, Maiden Sumame)	STHESS
	be fill Hod ot	Be	17. Father's Name (First, Middle, Last) Zachuros Zaid					Golomb	, maiger Sumame)	
2	should Ind Meni	ဥ		Free Orion	10h Maili	an Address (Street o			er, City or Town, State, Z	in Code)
	12 st h and 7 is n		19a. Informant's Name/Relationship (7 32nd St				p code)
ב	1 and Heelth Bm 27 ther tr		Hershel S. Lipo			sition (Name of matory or other place		Dale	20c. Location - City or 1	own, State
2	Pages nent of h ant: if ite		1 Burial 2 ☐ Cremation 3 ☐	Hemoval from State			1	20. 200		
antimor	it. Partitions rithers of the original property of the original propert		* 4 □ Donation 5 □ Other (Specifical Service Vicer			Gardens 2. Name and Addres		-20-200	Silver Sp	ring
מ	permit. Depart Import any inj		21. Signature of Farier at Service Great	tholland		Rapp Fur	neral Ho	me & Cre	emation Serv	ices
PI			25a. Perit. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate							
			shock, or heart failure. List only one cause on each line. Interval between Onset and Death Onset and Death							
	Physician /Medical		Immediate Cause (Final disease or condition resulting in dealh)							
	Examiner		Due to (or as/a consequence of):							
		-	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Output Due to (or as a consequence of): Cause (Disease or injury)							
	uted I	Examiner	cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last c. Due to (over a consequence of):							
	execu n and ial-tra	Exa	resulting in death) Last	Due to (or as a consec			366191		VD 171	
00/9	es that the death certificate be executed igned by the attending physician and be detached for use as the burial-transit	dicai	(d			1	- 1/	W.	
g	ifficat g phy as th	ě.					- (r	× ×	710	
Š	n cert andin use	Physician/M	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregpenty	13/13	201	ate of deli	
2	death le atten ed for u	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of o		Other (specify)	100	1	Month	Day Year
5	that the	hys	9 Unknown	9C ORRIOWII		Mon				
	as tha gned	by F	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	inderlying cause give	en in Part I.		tobacco use contribute to	
ğ	law requires as been sign 2 should be	ed						1 📗	Yes 2□No 3□Pro	bably 4 Unknown
	law re as be 2 sh	pie						24a. Was	psy prior to c	topsy findings available ompletion of cause of
	The lav	Completed						perfe 1 ☐ Yes	ormed? death? 2. No 1 ☐ Yes	2□ No
	ilcian: Th certificete rector, pag	Be C	25. Was case referred to medical examiner?					ath (Check only	one)	
	Physician: r this certific ral director,	To E	1 Yes 2 No	Hospital: 1 Inpatient 2	EP/Outpatie	nt 3 DOA Othe	er: 4 Nursing H		idence 6 Other (Spec	
0	ding Phys h. After this funeral di		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c. Injury Work	at	28d. Describe	how injury occurred ov	vido se
<u></u>	tendir Jeath. tor: Al	Certification:	2 Accident investigatio	D 04.1	125	0 0 M 1 □ 1	Yes 2 No	<u> </u>	in mus	•
	er de	tiffic	3 Suicide 6 Could not be determined	e 28e. Place of Injury - Al h building, etc. (Speci	ome, farm, st fy)	reet, factory, office		28f. Location (City or To	(Street and Number or Ru lwn, State) j 451 4	Homecres K
	itai o	Cel		home				Silver	Spring m	0
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier (Check only Check							
	the true the fundamental the f	Medi	one)	and manner stated.		29c. License	numbor		29d. Date signed (Month	Day Yoar
	To Too	~	29b. Signature and tille of certifier	1		29C. License	P P		23d. Date signed (Month	, Day, Teal)
	n		1/ Vulgare			1.) 6	137.5	,	111110	5
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marjorie Angella Pennant 1500 Forest Glen Rd. Silver Spring							or Chrin	20910		
			Marjorie Angell 31. Date filed (Month, Day, Year)	a Pennant 150		st gren k	m. DIIV	T OPILL	16 20710	
	Sta Regista		JAN 2 1 20	05	N A	- AP -				
DI	HMH 17 Rev 1/2	97	~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~	05 Bleen	- 19					
-					-					

		1 - For Stete Registrar	State of Maryland	_	rtificate of		Reg	200	5 013	
Physicia /Medic		1. Decedent's Name (First, Middle, Las	t)	LONG		NG	2. Date of Death Month JANUAR Y	Day Year		
Examin		4a. Facility Name (If not institution, give street and number) HAR BOR HOSPITAL			4b. City, Town, or Location of Death BACTIMORE			4c. County of Death N/A		
nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ordering the marked order Health and Mental Hygiene. Orderin: If them 27 Is marked other than "natural", or thems 23a or 28a-f show injury or other traumatic event. The Medical Eventinal must be notified at injury or other traumatic event.		5. Social Security Number 220 84 3963 1 Usual Residence of Decedent	7. Age (In yrs. Ia ☐ M 283 F 43	Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) OCt. 28,	^(ear) 1961 F	irthplace (State or Fo Sountry) Florida	
	tor	10a. State 10b. County Maryland Anne Ar		Town or Lo					10d. Inside City Li	
	al Dire	10e. Street and Number 422 Cresswell Road			10f. Zip Code 10 21225			g. Citizen of What C	Country?	
	by Funeral Director	11. Marital Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cub	dispanic Origin? (Spe an, Mexican, Puerto Specify:	ocify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: W	ite, etc.	
	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	dary (0-12) College (1-4or 5+)			oation during most of working d)	ng	16b. Kind of Business/Industry		
	To Be Cor	1 year Floral Designer F: 17. Father's Name (First, Middle, Last) Peter Long 18. Mother's Name (First, Middle, Maide June Kirkland				,				
alth and N 27 Is ma or trauma		19a. Informant's Name/Relationship (7 June Owen / Mo	ype, Print) other		ng Address (Street Cresswell	and Number or Rura L Road			Zip Code) and 21225	
Department of Health a fmportant: If item 27 is any injury or other tra		20a. Method of Disposition 1 Surial 2 □ Cremation 3 □	Removal from State	metery, crei	osition (Name of matory or other place) n Mem. P	ark 1/14/		c. Location - City o	rTown, State	
permit. Departition of the permit of the per		21. Signature of uneral Service Lion	ldridge		2. Name and Addre	ss of Facility Gon ie Highway	ce Funer	al Servi		
nysician Medical xaminer		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. SEPTIC 51+0 CK Due to (or as a consequence of): ASPIRATION PAREUMONIA 3.						Approximate Interval Betwee Onset and Dear 3 DAYS		
requires that the death certificate be executed signed by the attending physician and tould be detached for use as the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a conseque Due to (or as a conseque d	_					,	
	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	olivery Day Year	
been signed should be det	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc POST SURGERY (CHOLECYSTECTOMY) 1 Yes							co use contribute to the cause of deat 2 □ No 3 ☆ Probably 4 □Unk	
ertifi actor	Complet		, 				24a. Was an autopsy performe	prior to	utopsy findings avail completion of cause s 2 \(\sigma\) No	
	Certification: To Be	27. Manner of Death 1 K Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	t be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Numb							
within 24 To the Fi	Medical	29b. Signature and title of certifier Tavalus And manner stated. 29c. License number RESODI JANUAR 29d. Date signed (Month						th, Day, Year)		
			ompleted cause of death (Item 2)						1	

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend item 24a per mr 9839 1-21-05 vt
State of Maryland / Department of Health and Mental Hygiene = Stete Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month TAN Year **Physician** MC Dowell 6379M Harles 20 2005 /Medical 4a. Facility Name (If not institution, give street and number) MED±(AL 4c. County of Death 4b. City, Town, or Location of Death SYSTEM BALTIMERE, MD F

ours last birthday) If Under 1 Year III Under 24 Hrs. III (Month, Day, Year)

Hours Min. III (Month, Day, Year) **Examiner** BALIMORE UNIVERSITY OF MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 82 1**X**M 2□ F 216-12-5391 Yrs. Director 06.16.192 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "naturel", or Items 23a or 28a-f show ant: If item 27 is marked other than "naturel", or Internatic event, I're Madical Examiner man be notified at any or other traumatic event, I're Madical Examiner man be notified at 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits MD Baltimore 1 XYes 2 □ No Completed by Funeral Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Avenue 21229 USA 510 Normandy 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 🕱 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1,4or 5+) BAR **EMPLDYED** 10th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rose Mary George McDowell 2 19a. Inform t's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Sylvia Mc Dowell 510 Normandy Avenue Baltimore MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ott 1 SBurial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Baltimore MD DUDEN PARK 01.25-05 21. Signa are of Fureign Service Licens 22. Name and Address of Facility Vaughin C. Greene Funeral Service 5/5/Baltimolu National Pike Baltimore ND 21229 lau 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Spiration Physician Preum oriti HOURS disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner RONAL Sequentially list conditions, if any, leading to inhihediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 113 Due to (or as a consequence of): The law requires that the death certificate be axed attending physician a Box 68760, MVOCardAL Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Be Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No certificate 1 ☐ Yes Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA Other: ٩ 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 ☐ Accident death. 1 Tyes 2 🗌 No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 50 JAN, 20 2005 rung Name and address of person who completed cause of death (Item 3) (Type, Print) MAULTOB 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

		1- State of Maryland / Department of Health and Certificate of Death		ene .2005 01395					
Physic /Med		Decedent's Name (First, Middle, Last) Richard Dyas Massie	2. Date of Death Month 01/04/	Day Year					
Exami		4a. Facility Name (If not institution, give street and number) Gilchrist Hospice 4b. City, Town, or Location of De Towson Maryla	ath	4c. County of Death Baltimore					
Funeral Director		5. Social Security Number 026-40-8940 6. Sex 12 F 7. Age (In yrs. last birthday) 15 If Under 1 Year 15 If Under 24 H Months Days Hours Mi	8. Date of Birth (Month, Day, March 1	9. Birthplace (State or Foreign Country) 6, 1952 MA					
yland		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits					
he Mar 8e-f sh	ector	MD N/A Baltimore	10	1 X Yes 2 ☐ No					
uh with t	al Dir	10e. Street and Number 1001 St. Paul Street	10	USA					
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, the Modical Exact arminal to indiffed at proce.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Never Married 2 Married 1 Maried 2 Married 1 Married 1 Married 1 Married 1 Married 2 Married 1 Married 2 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 2 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Mar	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White					
21215-0036 bd within 72 hours afficient or then "natural; or then "the Medical Exercises."	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of w	working 1	6b. Kind of Business/Industry					
212 212 ad with rigiene.	Comp	Elementary/Secondary (0-12) College (1-4or 5+) Legal Secre	etary	Law Office					
Vland Vland Wental Hy arkad oth	To Be	17. Father's Name (First, Middle, Last) 18. Mother's N	lame (First, Middle, M Leda Difav	,					
Man ind 2 sho alth and 27 is mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or a street and Number o	Rural Route Number, Cambridg						
Baltimore, Maryland semit. Pages 1 and 2 should be file begerment of Health and Mental Hy mportant: if item 27 is marked oth miny injury or other traumatic event and a specific and a spe		20a. Method of Disposition 1	Date 2 /06/2004	Oc. Location - City or Town, State Baltimore City, MD					
Balti Permit. Depertrimports any injugates.		21. Signature of Funeral Sarvice Licensee Victor P. Doda Charles L. Steven: 1501 East Fort Av.	s Funeral enue, Balt	Home, Inc. imore MD 21230					
B760, Are be executed Examiner hysicien and the burial-transit	ical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
Box 61 death certific	Physician/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown		23d. Date of delivery Month Day Year					
Cords, P w requires that been signed b	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?					
1 0 0 0 N	Completed		24a. Was an autopsy perform	prior to completion of cause of					
of Vital of Vital Physician: 1 this certifica	BeC	25. Was case referred to medical 26. Place of D	eath (Check only one						
ARI on of iling Phys. After this	tlon; To		Home 5 Residen	ice 6 (\$Other (Specify) 1 0 \$1 (0)					
Division or Attending etter death. Director: After	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	Pet and Number or Rural Route Number, State)					
Division Division Division To the Hospital or Attent within 24 hours efter death To the Funaral Director: completely filled in by the y	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ce, and due to the cau curred at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)					
To the within 2 To the comple	Ne S	29b. Signature and title of certifier 29c. License number		d. Date signed (Month, Day, Year)					
-61		D005792	6	January 4, 2005					
		30. Name and address of person who completed cause of death (flem 23a) (Type, Print)							
St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 2. 1 2005 Registrar's Signature							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:05 AM HERMAN Muhibauer January 18 2005 carl /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
- [9-1920 9. Birthplace (State or Foreign Country)

MAL / LAND 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Days 1**M**M 2□F 219-05-8891 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "naturel", or items 23a or 28e-f show the Medical Exercitive must be political at 1 ☐ Yes 2 X No BALTIMORE Director TORKULLE Street and Number 10f. Zip Code 10g. Citizen of What Country? WOLVERION USA 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myss 2 □ No If Yes, Give Year or Dates: 46.47 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: Specify: WHITE ģ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) ACKSMITH mit. Pages 1 and 2 should be filed with and Mental Hygier partment of Health and Mental Hygier portent: If item 27 Is marked other the yinjury or other treumatic event, Ital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MUHLBAUER HERESA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1188 WOLDERION KD YARKUILE MD WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1. ■ Burial 2 □ Cremation 3 □ Removal from State Date 20c. Location - City or Town, State UAD Timosium, MD permit. Page Department i importent: If any injury or once. 4 □ Donation 5 □ Other (Specify) DWEY VALLEY 2005 22. Name and Address of Facility EVALS CHAPEL OF MEMORIES 21. Signature of Funeral Service licensee 8800 HARFORD MOIZZO RD. BALTIMORE, MD 21254 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemorrhage **Physician** Intracrania disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760 the attending physician The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 ∪лклоwп 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown coronany Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Disease 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Minpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospitel or Attending 5 Pending investigation 1 Natural after death.

Director: All 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours at To the Funerel D 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18th, 2005 M.D. RES -000 January 8 on who completed cause of death (Item 23a) (Type, Print) Rachel Blueband-Baltimore MD 21224 Langher-4940 Avenue Eastern 52. Recintrar's Signature 31. Date filed (Month, Day, Year) State 2005 Registrar

		For	State of Maryland	d / Depa		Health and M	ental Hygi	ene	0100
Physic /Medi			SONALD	Cei			2. Date of Death Month	Dayth Year	3. Time of Death
Exami Funeral Director		4a. Facility Name (If not institution, give s Northwest Hospi 5. Social Security Number 213-32-9855	tal Center	as <i>t birthday)</i> Yrs.			8. Date of Birth (Month, Day,) July 26	Baltimor (ear) 1908 MI	
D		Usual Residence of Decedent 10a. State 10b. County MD Carrol1	10c. City	, Town or Lo	Marriott	sville			10d. Inside City Limit
ING 21213-UU36 be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or Items 23a or 28a-f show event, its Medical Exaral or must be rediffed at	Funeral Director		2. Was Decedent Ever in U.S Amed Forces?	S. 13.	10f. Zip Code 2110 Was Decedent of If Yes, specify Cub)4 Hispanic Origin? (Spe pan, Mexican, Puerto I		g. Citizen of What Co USA 14. Race - Ame Black, Whit	erican Indian,
7 5-0030 n 72 hours aft "natural; or edical Exam	Completed by F	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced 15. Decedent's Educ (Specify only highest grade		16a. Dece	I ☐ Yes 2 ☑ No Ient's Usual Occu kind of work done DO NOT use retire	pation during most of working	16	Specify: Wh	
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours alt partment of Health and Mental Hygiene. portent: If Item 27 is marked other then "naturel", or y injury or other treumatic event, the Medical Exam. Re.	Be	17. Father's Name (First, Middle, Last) Pierce Prough	College (1-4or 5+)			Volunteers 18. Mother's Name Mamie ((First, Middle, Ma	Hospita1	
ore, Maryla	To	19a. Informant's Name/Relationship (Type Mrs. Sarah Fettero 20a. Method of Disposition	lf (Daughter)	7025			, Marrio		MD 21104
Baltimori permit. Pages: Department of h Importent: If Its any injury or of once.		1 Burial 2 Cremation 3 Resident A Donation 5 Other (Specify) 21. Signature of Figheral Service License	emoval from State Wes	netery, crer 1ey Fr	eedom Ce	emetery 1/2	22/05	Sykesville	e, MD
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Medical transit and the price and white-franching-franch	Ical Examiner	Sequentially list conditions, if any, reading to in mediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or accessive to (or accessive to (or accessive to (or accessive to (or accessive to (or accessive to (or accessive to (or accessive to (or accessive to (or accessive to (or accessive to (or accessive to (or accessive to (or accessive to (or accessive to (or acce	rence of):	BSTRUC	MAT FAI	nemnky.	DISGASO	
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	e Completed	25. Was case referred to medical					/	prior to o	topsy findings available completion of cause of
tending leath. tor: After the fune	Certification; To Be	eyaminer?	(Month, Day Year)	28b. Time of Injury	28c. Inju. Wo	ryat 2 rk?]Yes 2 □ No	ne 5 🗆 Residence 8d. Describe how		
spitel or hours afte inerel Dir		4 Homicide determined 29a. Certifier 1 Certifying Phys	28e. Place of Injury - At hor building, etc. (Specify, ician: To the best of my know er: On the basis of examinating) vledge, death	occurred at the ti	me, date and place, a	City or Town, I	se(s) and manner as	stated.
To the Ho within 24 I To the Fu	Medical	29b. Signature and title of certifier	er: On the basis of examinati and manner stated.		29c. Licens	se number	7 c	Date signed (Month	, Day, Year)
Sta Regist	ate rar	30. Name and address of person who con ANRTH LIEST AUS (31. Date filed (Month, Day, Year) JAN 2 1 2005	32. Registrar's Signati	R		NOER PM STOWN N		33.	

DHMH 17 Rev 1/2001

ORIGINAL

		,	For State Registrar	•	Department of Health a Certificate of Death		giene lag. No.	01398
	Physicia		1. Decedent's Name (First, Middle, Last	mc C	loud	2. Date of Dea Month	Day 2005	3. Time of Death 5.30 AM
	/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give) 05eph Ritchie 5. Social Security Number 6. Se 219-26-2455	street and number) HOSOICE × 7. Age (In yrs. last birt	4b. City, Town, or Location o Baltimore	Death	4c. County of Deat	
•	D.	or	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town		III MIN. W	, 175 / 1	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	death with the Maryland ims 23a or 28e-f show rmust be notified at	Direct	10e. Street and Number 145 6169war		10f. Zip Code 2/329		10g. Citizen of What Co	untry?
036	9 E	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes, 2 10 Mo If Yes, Give Year of Dates:	13. Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican 1 ☐ Yes 2 ☐ No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)		
21215-0036	d within 72 hor jiene. Ir than "natura	Completed	15. Decedent's Edu (Specify only highest grad	College (1-4or5+)	Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)	of working	16b. Kind of Business/Warehou	
Maryland	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Me	To Be C	17. Father's Name (First, Middle, Last)		18. Mother LS a	's Name (First, Middle,	Maiden Sumame) JellS	
-	c, Mal y la		9a. Informant's Name/Relationship (7)	- Sister 14	Mailing Address (Street and Number 5 Signart Lr.) Disposition (Name of	r or Rural Route Numbe Bolto. M	r, City or Town, State, 2 D 21239 20c. Location - City or	
S 3C A A A A A A A A A A A A A A A A A A	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 is any njury or other tre		1 Burial 2 ☐ Gremation 3 ☐ F 4 ☐ Donation 9 ☐ Other (Specify)	Removal from State MT. Zi	y, crematory or other place) on Cemetery 1-	24-05	ansdowne	mo
	Departing any in sonce.		21. Signature of Poneral Service Ucens 23a. Patr Aley n sease, or comp	nel		270 Fredhil		
90	Physician /Medical		shock of year failure. List only o Immediate C use (Final disease of ondition resulting in death)	lica on that caused the death. Do not cause on each line. a. Due to (or as a consequence of	TIC CANO	ardiac or respiratory and	est,	Approximate Interval Between Onset and Death 3 Months
S1 4 09/8	cate be executed by physician and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b				
Sox 68	death certifi e attending of for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	very Day /Year
) @ (uires that the signed by the Id be detache	by	Part II. Other significant conditions co	ntributing to death but not resulting in	the underlying cause given in Part I.	23e. Did to	bacco use contribute to es 2 ⊠No 3 ☐ Pro	the cause of death?
(C =	The faw requires ate has been sign page 2 should be	Completed				24a. Was a autop: perfor	sy prior to o med? death?	topsy findings available completion of cause of
CEND @	ng Phya fter this	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		Othor			ily) HOSPICE
Division	To the Hospitei or Attandi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28I. Location (S City or Tow	treet and Number or Ru n, State)	ral Route Number,
/_	he Hospi in 24 hour he Funer pletely fill	Medicai		rsician: To the best of my knowledge iner: On the basis of examination and and manner stated.		h occurred at the time, o	late and place, and due	to the cause(s)
	To t To t	M	29b. Signature and title of certifier	and	29c. License number		29d. Date signed (Month	
	7		30. Name and address of person who c	ompleted cause of death (Item 23a) (32. Registras Signature 1 2005	Type, Print) 2) N. EUTAW	ST BAL	TMORE	MD 21201
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2	32. Registra's Signature 1 2005	to Speaker			

State of Maryland / Department of Health and Mental Hygiene 01399 For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15 2005 ear **Physician** Jan. LINDSEY MARLOW 10:00 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Glen Burnie Anne Arundel 467 Lincoln Drive If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1⊠M 2□F Director 83 23.1921 North Carolina 243-12-3904 June Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature." 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Directo Anne Arundel Glen Burnie Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21060 U.S.A. 467 Lincoln Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1

Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Yes, Give ear or Dates: W. W. II þ Specify: Black 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steelworker Beth. Steel Corp. N/A 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ပ Marlow Bessie Lucian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 467 Lincoln Drive Glen Burnie. Maryland 21060 Ruth Marlow (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville. V.A. Cem. 1/21/05 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully—Polyniak Funeral Home 3204 Mountain Road Pasadena, 21. Signature of Fundral Service Licensee Home, P.A. 21122 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ROSEPSI. /Medical Due to (or as a consequence of): Examiner TRACT INFECTION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 pronths?
1 Yes 2 X No Day 4☐Pregnant at time of death signed by the at Id be detached fo 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 1 🗌 Inpatient ٩ 1 Yes 2 No 3 DOA 2 ER/Outpatient 5 Residence 6 □Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 2 No 1 Tes 2 Accident investigation Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours a To the Funeral D 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature a title of certifie 038635-2005 CV MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FORT HOWARD. MI) 2/05 9600 NORTH KISHORE JAN 2 31. Date filed (Month gistrar's Signature State 2005 Registrar

			For State Registrar	State of Ma	•		of Health a	and Mental Hy	giene Reg. No.200	5 01400
	Physici /Medi Examir	cai	1. Decedent's Name (First, Middle LINDA 4a. Fecility Name (If not institution HARBOR H).	JEAN give street and number)	MENTER		A vn, or Location o	_	Day Ye 26 4c. County of [3. Time of Death POS OF: STAM Death N/A
	Funeral Director		5. Social Security Number 218-60-9762 Usual Residence of Decedent	•	(In yrs. last birth	s. Months Da	ear If Under 2 ays Hours	Min. 8. Date of Bi (Month, D		Birthplace (State or Foreign Country) Maryland
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Modisal Examinat requisite profiliad at once.	To Be Completed by Funeral Director	Maryland Balti 10e. Street and Number 628 47th Str 11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced 15. Decedent (Specify only highes Elementary/Secondary (0-12) 12th Grade 17. Father's Name (First, Middle, Informant's Name/Relations) Mrs. Shannon L 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (St.) 21. Signature of Euseral Service I	2.et, Apt. RW 12. Was Decedent E Armed Forces? 1 Yes 2 X N	19b. Place of Ecometery, Bayviet	Baltin 101. Zip Cod 113. Was Decedent If Yes, specify of the sind of work of the sind of work of the sind of work of the sind of work of the sind of work of the sind of work of the sind of work of the sind of work of the sind of work of the sind of the sin	of Hispanic Original Cuban, Mexican, Mexican, Mexican, Mexican, Mexican, and during most attired) 18. Mother Maxican	gin? (Specify Yes or N. Puerto Rican, etc.) of working of working of Name (First, Middle Valene Jone or Fural Route Numb Date /20/05 Schimune Baltimor	Specify: 16b. Kind of Busing Own How, Maiden Surmame) Some, City or Town, State Cach, SC 20c. Location - City Baltimore R Funeral e, MD 212;	A. American Indian, White, etc. White ess/Industry Ome te, Zip Code) 29577 y or Town, State Homes
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DHMH 17 Rev 1/2001

ORIGINAL

		1- State of Maryland /	•	tificate of			R	eg. No.	005	01101
Physici /Medic		Decedent's Name (First, Middle, Last) JUDY TERESA MILESKIE					Date of Dear Month JAN	f8y	2005	9:45A M
Examin		4a. Facility Name (If not institution, give street and number) 4106 Putty Hill Avenue		4b. City, Town, o Baltimo:			-	4c. C	ounty of Death altimor	е
Funeral Director		5. Social Security Number 6. Sex 1	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	vin.	Date of Birth (Month, Day, Uly 31	Year) , 19	9. Birthp Cour PA	place (State or Foreign ntry)
Maryland a-f show ified at	tor	10a. State 10b. County 10c. City, To Maryland Baltimore	own or Lo		timore	Coun	ty		1	0d. Inside City Limits 1 ☐ Yes 2 🕅 No
with the sa or 284 Les nut	i Direc	10e. Street and Number 4106 Putty Hill Avenue		10f. Zip Code	21236		1	0g. Citize	n of What Cour	itry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "netural", or Items 23a or 28a-f show appringing or other treumatic event, I'm Medical Engit fact main to Indiffect at once.	y Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes X No If Yes, Give Year or Dates:		Vas Decedent of H f Yes, specify Cubi □ Yes 2 No	lispanic Origin' an, Mexican, Pi Specify:	? (Specify uerto Rica	Yes or No- an, etc.)		. Race - Americ Black, White, pecify: Wh	
within 72 hou ane. Ihan "netura in wedical E	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		dent's Usual Occup kind of work done DO NOT use retired	ation during most of t)	working			of Business/Ind	own Home
ild be filed v ental Hygie ked other i ic event, II	To Be Co	12 yrs. N/A 17. Father's Name (First, Middle, Last) John Swartz	HOM	emakei	18. Mother's Jul			Maiden Su		OWIT HOME
and 2 shou salth and M n 27 is mar er treumat	-	19a. Informant's Name/Relationship (Type, Print) Joshua A. Hardin (Grandson)		g Address <i>(Street</i> 6 Putty						
Pages 1, Iment of He tent: If Iten jury or oth		XIX Burial 2 Cremation 3 Removal from State Garde	ens o	sition (Name of natory or other plac f Faith	Cem. 1-	Date -212			tion-City or To imore,	
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2 mile of a mile of	M	29b. Signature and title of certifier			3929			1	igned (Month, I	
Α/		30. Name and address of person who pleted cause of death (Item 23a MICHAEL K. 126, MI). 2314 and 31. Date filed (Month, Day, Year) 32. Registrar's Signature JAN 2 1 2005	a) (Type, F	Print) Luppa K	id. 7.	BAH	6 MD	ري ر	1234	
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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Maddox, Saundra Baltimore. Marvland 21215-0036

Division of Vital Records. P.O. Box 68760.

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			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that saused	the death	. Do not ente	r the mode of dyi	ng, such as card	e, Balt	LMO1	re, Md	Approx	2 1 5
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/Mec	lical		disease or condition resulting in death)	Due to (or as:			reast	Cano	er			Esy	ears
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			1 - For State Registrar	State of Mar	yland / Depa		Health and I	Mental Hyg) 5	01403
			1. Decedent's Name (First, Middle, La	ist)				2. Date of Deat			3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution, gir			4b. City. Town.	or Location of Deatl	<u> </u>	4c. County		7.10 p
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	Funeral Director			. W	35 Yrs.	Months Days		Dec. 30	Year)	Cour	lace (State or Foreigr etry)
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	within 72 hours after death with the Maryland ene. Itan "natural", or Itama 23a or 28e-f show ha Madical Examinat must be notified at	by Funeral Director	14 Austin Drive	12. Was Decedent Eve	110		037		USA	Americ	an Indian,
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	1 and 2 Heelth tem 27 other tr		Anne L. Manuel	(Wife)		- 20	ive, Edge		21037		
Baltimore,			20a. Method of Disposition		20b. Place of Dispo cemetery, crea	osition (Name of matory or other pl	ace)	Date 2	0c. Location -	City or To	wn, State
Ë	Pages nent of P ant: If its ury or o		1 ☐ Burial 2 XI Cremation 3 [14 ☐ Donation 5 ☐ Other (Special Control of Co		Metro Cr	-	· •	0/2005 E	Baltimo	re. N	MD .
₽	in in in in in in in in in in in in in i		21. Signature of Funeral Service Lice							, .	
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			23a Part1 Enter the disease, or con	polications that caused th	e death. Do not ent) 214	Approximate
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each line.			/	1			Interval Between Onset and Death
	Pnysician	1	Immediate Cause (Final disease or condition resulting in death)	_ a (enebr	vas a	alan A	cciden	T		Byears
	/Medical Examiner		resulting in dealiny	Due to (or as a c	consequence of):						
H.	Lxammer	,	Sequentially list conditions.	b							
	p #	ine	Sequentially list conditions, if any, leading to immediate cause. First Indentying Cause (Disease or injury that initiated events	Due to (or as a o	consequence of):						
	le be executed ysicien and e burial-transit	Examiner	Cause (Disease or injury that initiated events	c							
Ó	en a		resulting in death) Last	Due to (or as a o	consequence of);						
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9	leath certificate attending physi i for use as the l	edi							-1		
ŏ	The law requires that the death certifica tte has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		70.			23d. Date	of delive	ery
Ď	death a atte	cia	in the past 12 months? 1 □ Yes 2 ☑ No	1 ☐ Live birth 2 (4 ☐ Pregnant at tin		□Ectopic pregnand □ Other (specify) □	cy		Mon	ith	Day Year
o.	the c y the	ysi	9 ☐ Unknown	9□ Unknown							
م	res that the de igned by the a be detached i		Part II. Other significant conditions	contributing to death but r	not resulting in the u	nderlying cause g	iven in Part I.	23e. Did tob	acco use contri	ibute to th	ne cause of death?
ds	urres sign ld be	d by						1 □ Ye	s 2 🗆 No	3 🗌 Prob	abiy 4 Uluk nown
ecords,	w requ	Completed									
ec	e law has t	npi						24a. Was ar autopsy	, b	rior to cor	psy findings available npletion of cause of
		Ö						perform 1 ☐ Yes 2		eath? □ Yes	2 🗆 No
Vital	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one)		
>	d is	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA	ther: 4 Nursing H	ome 5 Reside	nce 6 Othe	r (Specify	1)
			27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time o		ury at	28d. Describe hor	w injury occurre	ed	
Division	nding l ath. r: After e funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		our, injury		Tes 2 □ No				
/is	or Attendi after death. Director: A in by the fu	fica	3 ☐ Suicide 6 ☐ Could not I	286. Place of injury	- At home, farm, sti	reet, factory, office)	28f. Location (Str		r or Rura	l Route Number,
ă	after Direction by	Certification;	4 Homicide determined	building, etc. (Specify)			City or Town,	State)		
	spite ours nerel filled		29a, Certifier 1 Certifying P	hysician: To the best of r	my knowledge, deat	h occurred at the	time, date and place	and due to the ca	use(s) and mar	ner as st	ated.
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	(Check only 2 Medical Exa	miner: On the basis of ex	kamination and/or in	vestigation, in my	opinion, death occu	rred at the time, da	te and place, a	nd due to	the cause(s)
	thin the mple	Me	29b. Signature and title of certifier	and manner states		29c. Licer	nse number	29	d. Date signed	(Month.	Dav. Year)
	Z = Z = S		I I I I W	10.00 A				-	, / ,	1/	25
	\mathcal{T} .		twenty	(I MY		100	5848		1110	10	
	10		30. Nat e a d address of person wo	completed cause of dear	th (Item 23a) (Type,	Print)	C il		1	1.	021054
			Johand K S	chalte	J ~ - /	7371/2	Pense H	y ban	bnill.	, M	1) 21057
	Sta	te	31. Date filed (Month, Day, Year)		Signature	36		/			
	Registr	ar	2 1 2	005 Deles	. K A	and all is					

			For State Registrar	State of Mai		artment of H			giene Reg. No. 2005	011.01.
	Physici		Hegistrar Decedent's Name (First, Middle, L Helen Mille			inodio or i		2. Date of De Month	ath Day Year	3. Time of Death 5 01:45 M
	/Medic Examir Funeral		4a. Fecility Name (If not institution, grands Hopkins 5. Social Security Number 6.	be street and number) Bayview Me	edical Center	4b. City, Town, or Baltim	Cre If Under 24 Hr	s. 8. Date of Bird	4c. County of Deal	thplace (State or Foreign
	Director		239-01-8808 Usual Residence of Decedent 10a. State 10b. County		Yrs.	Months Days	Hours Mir	May 25		th Carolina 10d. Inside City Limits
	ith the Marylar or 28e-f show e rediffed at	rector	Maryland Howar	_	Ellicott				10g. Citizen of What Co	1 ☐ Yes 2 📉 No
	23£	Funeral Director	11. Marital Status	Branch Lane 12. Was Decedent Ev	10/2	21043 Was Decedent of Hilf Yes, specify Cuba	ispanic Origin? (Specify Yes or No	U. S. A. 14. Race - Ame Black, Whit	
215-0036	2 hours after neturel; or blocal Exercit	b	1 Never Married 2 Married 3 Widowed 4 Divorced		1945	1 ☐ Yes 2X No	Specify:	orking	Specify: Wh	
21	filed within 7 Hygiena. other than "n	Completed	(Specify only highest g Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Las	College (1-4or 5+)	life.	emaker)	-	Own Ho	me
Maryland	2 should be fi and Mental H Is markad ot eumetic ever	To Be	Thomas C. Maye 19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street a	Estell	e E. Rope		Zip Code)
Baltimore, Ma	Pagas 1 and 2 nent of Health a ant: If item 27 li ury or other tre		Edwin B. Miller 20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	300 20b. Place of Dispo cametery, cree Wood Lawn	6 E. Autu esition (Name of matory or other plac Cemetery		ch Ln. I	Ellicott Ci 20c. Location - City or Woodlawn,	
Balti	permit. Pag Department Important: I any injury o		21. Signature of Funaral Service Lice	-932	A. I	Name and Address mbrose Fu 328 Sulph	neral H ur Spri			
	Pnysician /Medical		23s. Part1. Enter the disease, or co- shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	y one cause on each line	ne death. Do not ent	er the mode of dyin	g, such as cardia	ac or respiratory ar	rrest,	Approximate Interval Between Onset and Death
8760,	examine the executed the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Jasass of Hyu y that initiated events resulting in death) Last	c	consequence of):					
.O. Box 68	the attending properties the attending properties as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tii 9□ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
4	quires that the signed by all be detacted	by	Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause give	en in Part I,	23e. Did to	obacco use contribute to Yes 2 No 3 ☐ Pr	
l Records,		Completed						24a. Was autop perio 1 Tyes		atopsy findings available completion of cause of 2 No
Vital	ysician: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:	2 ☐ ER/Outpatier	nt 3 DOA Othe	20	eath (Check only o	ne) dence 6 □Other (Spe	cify)
ion of	ding Ph n. After th funeral	atlon; T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day)	28b. Time of	28c. Injury Work			now injury occurred	
Division		Certification;	3 ☐ Suicide 6 ☐ Could not determine	d 286. Place of Injury building, etc.				City or Tox		
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical		Physicien: To the best of eminer: On the basis of e and manner state	xamination and/or in					
	To t To t	Σ	29b. Signature and title of certifier Solon with Z	· Cumis	4.0	29c. License		1	29d. Date signed (<i>Mont.</i>	
7	10		30. Name and address of person wh		1th (Item 23a) (Type, 940 Ea)	Res tern a	e-Bat	ter Mol.	21224	
Į.	Sta Registr	24	31. Date filed (Month, Pay, Year) JAN 21	2005 32. R Strar	s Signature	book)		

CPM 05-00207 Tina Minkle

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item 23a, 27, per, ME, C840, 2717/05 TT

ΤΠ	a Minki	.e	Unpend item# 1_ For 1_ State	tate of Maryland		artmeni rtificate			and Me			005	014	105
			Registrar 1. Decedent's Name (First, Middle, Last)		061	incatt	5 OI L	Calli	1 2	R. Date of Deat	eg. No.		3. Time of I	Death
Н	Physicia	an	Tina Marie Minkle							Month anuary	Day	Year 2005	20:14	M
	/Medic		4a. Facility Name (If not institution, give street	at and number)		4b. City.	Town, or	Location of		andary		inty of Death		
	Examin	er	Saint Agnes Hospita					more				N/A		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under	1 Year	If Under 2	24 Hrs. 8	B. Date of Birth	- Variab	9. Birth	place (State or	Foreign
	Director		216-84-5527	¾ □ F 2	8 Yrs.	Months	Days	Hours	Min.	(Month, Day, an. 10			intry) aryland	
	D		Usual Residence of Decedent											
	show	E	10a. State 10b. County	10c. City	, Town or Lo	cation							10d. Inside City 11☑ Yes	
	Ba-1	cto	MD N/A					more						
	vith th	Funeral Director	10e. Street and Number			10f. Zip	Code			1		of What Cou		
	s 23s	ral	2514 Wilkens Avenu		0 421	Was Daniel		21223		if . Vaa ar Na		ted S		
	item item	une	11. Marital Oraliso	Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☆No	5. 13.	If Yes, spec	ify Cubar	n, Mexican,	, Puerto Ri	ify Yes or No- ican, etc.)		Black, White		
99	irs af	by F		If Yes, Give X. Year or Dates:		1 ☐ Yes 2	2⊠ No	Specify:			Spe	ecity: Whi	te	
ĕ	within 72 hours after death with the Maryland ene. than "hatural", or items 23e or 28e-f show the Medical Exact met ment be notified at	ted	15. Decedent's Education		16a. Dece	dent's Usua	I Occupa	tion		- 1	16b. Kind o	f Business/I	ndustry	
212	hin 7.	ple	(Specify only highest grade of Elementary/Secondary (0-12)	mpleted) College (1-4or 5+)	life.	kind of wor DO NOT us	k done d se retired)	unng most	t of working	7				
217	d with	Completed	11			Hon	nemak	er				Own Ho	ome	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than 'natural', or litems 23a or 28a-1 show aumatic event, the Medical Esan finer matter codified at	Be (17. Father's Name (First, Middle, Last)					18. Mother	r's Name (First, Middle, I	Maiden Sun	name)		
<u>Va</u>	ould be Mental arked o	To I	Timothy Smith							a Smith				
a	2 shc and is my		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailir	ng Address	(Street a	nd Numbe	er or Rural I	Route Number	. City or To	wn, State, Zi	ip Code)	
2	and ealth m 27 ner tr		<u>James Minkle - Hu</u>						Balt:	imore,			Ct-t-	
Ore	ges 1 t of H if ite or otl		20a. Method of Disposition 1	oval from State	ace of Dispo emetery, crer			- 1			20c. Locatio	on - City or T	own, State	
altimore,	tmen tant:		4 □ Oonation 5 □ Other (Specify)	Lou	don Pa							more,		
Bal	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.		21. Signatura in Funeral Source Essen	TOWN OF	12	2. Name an	a Addres	C	Amb:	rose Fu	neral	Home	, Inc.	
			23a. Part1. Enter the disease, or complicati	ons that caused the death						Rd., Ar		, MD 2	ZIZZ/ Approximate	
			shock, or heart failure. List only one of Immediate Cause (Final	ause on each line.			,			, , , , ,		Ì	Interval Betw Onset and D	
	Priysician /Medical		disease or condition resulting in death)	Asthma Due to (or as a consequ	ionco of):									
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Ó,	en ar urial-t		resulting in death) Last	Due to (or as a consequ	ience of):									
8760,	law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Medical	d											
<u> </u>	death certifica attending ph d for use as th	Med	IF FEMALE:											
Вох	that the death cer ed by the attendin detached for use	lan/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregna	death 3	Ectopic pr					23d.	Date of deliving Month		ear
	the a	yslc	1 ☐ Yes 2 ☐ No 9 ☑ Unknown	4□Pregnant at time of de 9□Unknown	eath 5	Other (sp	өспу)							
P.0	that the by detac	/ Ph	Part II. Other significent conditions contrib	uting to death but not resu	ılting in the u	nderlying c	ause give	n in Part I.		23e. Did tol	pacco use c	contribute to	the cause of de	eath?
Records,	uires tha signed Id be det	d by								1 □ Ye	s 2 🗆 No	3 🗆 Pro	bably 4 📈	nknown
200	w requir been si should	lete								24a. Was a	n 24	b. Were aut	opsy findings a	vailable
Re	iician: The lav certificate has rector, page 2	Completed								autops	ned?	prior to co death?	ompletion of ca	use of
Vital	ysician: The is certificate hadirector, page	e C	25. Was case referred to medical					26 Place	of Death /	1 Yes 2 Check only on	el No	ILJ Tes	2U NO	
>		To B	examiner? 1 X Yes 2 □ No	oital: 1 Inpatient	ER/Outpatier	nt 3 DC	Othe			e 5 🗆 Reside		Other (Speci	ity)	
0	g Physier this neral di	T:u		28a. Date of Injury (Month, Day Year)	28b. Time o	f 2	8c. Injury Work	at	28	d. Describe ho	ow injury oc	curred		
Division of	Attending in death. ector: After by the funer	atic	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation			М		fes 2□N	No					
Ν	or Atter de after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		reet, factory	, office		28	If. Location (St City or Town		ımber or Rui	rai Route Numb	er,
	ospitat o hours at uneral D ly filled in	Ce					O A Post							
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Physici Medical Examiner	an: To the best of my know On the basis of examinat and manner stated.	wledge, deat tion and/or in	h occurred vestigation	at the tim , in my op	e, date and inion, deat	d place, an th occurred	d at the time, d	ause(s) and ate and plac	manner as ce, and due	stated. to the cause(s)	
	To the within 7 To the comple	Med	29b. Signature and title of certifier			290	. License	number		2	9d. Date siç	gned (Month	, Day, Year)	
	- s - ō		> Bert 7 Mi	itin m			0.0	C.M.E.		Ts	ากและข	09,	2005	
			30. Name an address of person who comp	leted cause of death (Item	23а) (Туре,	Print)		LJ	-	DC	uar y	· · · ·	_003	
			GERTEMO	RION		Penn	Stre	et, I	Balti	more, N	Maryla	and 21:	201	20.00
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	f.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2005 16 Lora Tapp Manouelian 4:00p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Collingswood Nursing Center Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 04-24- Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗗 F 71 409-50-1519 Tenn **Director** Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits rthen "natural", or Itams 23a or 28a-f shor the Medical Examiner must be notified at 1 X Yes 2 □ No Funeral Director MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Duke Court 20850 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ Yes 2 No Specify: 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Office Manager 12 Construction ges 1 and 2 should be filed on of Health and Mental Hygie if itam 27 is marked other to or other traumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Tapp Rachel Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary G. Manouelian 2 Duke Court Rockville MD 20850 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages = 5 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. 01-20-2005 Beltsville Chesapeake Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rapp Funeral & Cremation Services or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 27a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Lung Cancer /Medical Due to (or as a consequence of) Examiner Pneumonia Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that in its and or injury that injury that in its and or injury that injur Due to (or as a consequence of) Physician/Medical Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Dav Year 4☐Pregnant at time of death 5 Other (specify) P.O. | ed by the a been signed be should be detr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2x No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 X No 1 Tyes 2 XNo Hospital or Attanding Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 🙀 No 2 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending urs after dea.

••f Director: A

•• by th 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funaraf L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) tha 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2005 7124 1/19/05 seo mo

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

Trong Bao 13219 Executive Park YTerrace Germantown MD 20874

Elsen & Spelle

32. Registiar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

31. Date filed (Month, Day, Year)

	4	For State	State of M	•		ate of L			-	UUT) U	407
	_	Registrar 1. Decedent's Name (First, Middle, Las	etl	-	Certino	ale of L	Jeani	2 Date of D	Reg. No	0.		0 T 10.
sician								2. Date of D Month	Da		Year	3. Time of Dea
edical	1		Donald Eug					Janua	ry 1:	1 20	05	6:25 P.
miner	r '	4a. Facility Name (If not institution, give)	4b. 0	City, Town, or	Location of De	ath	40	c. County o	f Death	
		North Arundel Ho	spital			Glen	Burnie			Anne	Aru	ndel
ral	:	5. Social Security Number 6. S		ge (In yrs. last	Mon	nder 1 Year ths Days	If Under 24 H Hours Mi		irth)	9. Birthpla	ace (State or For
tor	L	219 40 0456	1 M 2□ F	61	Yrs.			Aug. 4	, 19	43	Mar	yland
	-	Usual Residence of Decedent		T								
		10a. State 10b. County			own or Location						10	d. Inside City Lir
150	3 1	Maryland Anne Ai	rundel	Gle	n Burni	е						1 ☐ Yes 2X
Director	2	10e. Street and Number			10f	. Zip Code			10g. Ci	itizen of Wh	nat Count	ry?
		7221 Crown Road				2106	0			U.S.		
Funeral	2	11. Marital Status	12. Was Decedent		13. Was D	ecedent of Hi	spanic Origin?	(Specify Yes or Norto Rican, etc.)	0-	14. Race		
Ē	3	1 Never Married	Armed Forces? 1 1 Yes 2 □		If Yes,	specify Cuba	n, Mexican, Pue	erto Rican, etc.)		Black	, White, e	itc.
2	2	3 Widowed 4 Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:	Viet Na	am 1 🗆 Ye	es 201 No	Specify:			Specify:	Whit	:e
P	3	15. Decedent's Ed	ducation	1 16	6a. Decedent's l	Usual Occupa	ntion		16b K	Cind of Bus	iness/Indi	ustor
Completed	<u> </u>	(Specify only highest gra	ade completed)		(Give kind of	f work done of	luring most of w	orking	100.1	and of Das	mess/mai	ustry
E		Elementary/Secondary (0-12)	College (1-4or	5+)	Police				77-	. 1 . 2		
		47 Sahada Nama (Sina Aliddia 1 an)	2 years		LOTICE	serge				altimo		City
Be	ŏ	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle	e, Maider	n Sumame,)	
ု	2	James Pa	aul Morgar	1			R	ose Cer	ne			
1	-)	19a. Informant's Name/Relationship (Rural Route Numi	ber, City	or Town, S	tate, Zip (Code)
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State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day MCEIroy MOM Januar 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BUYY If Under 24 H Arunde oita 6 Arundel 8. Date of Birth (Month, Day, Year) April 30,1954 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min 1 □ M 2 1 F Director 168 46 6518 50 Yrs. Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 7 is markad other than "natural", or Itams 23a or 28a-f show traumatic event, Ite Medical Exartative ritual by multiled at 10d. Inside City Limits Director Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 6903 Glenridge Circle Apt. A2 21061 U.S. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1980 Porces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ If Yes, Give Year or Dates: to 1984 Specify: Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) 3 years Elementary/Secondary (0-12) Nurse Bella Machre and Mental Hygin is markad other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H sant: If Itam 27 is marked oil (not available) Militti Hilda Faust 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan McElroy / Daughter 6903 Glenridge Circle Apt. A2 Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 010 1 □ Burial 2 T Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 1/21/2005 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee amerouski 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complirations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** oronan /Medical Due to (or as a consequence of): Examiner ialetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-transit pertension Due to (of as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medicai 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 Yes 2 PNo or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Diractor: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D005885 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Priya Prabhakar 1600 Crain Highway Suite 408 Glen Burnie, Maryland 21061 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar JAN 2 1 2005

			For State Registrar	State of Maryl		artment of F rtificate of			-000	01409
			Registrar 1. Decedent's Name (First, Middle, Las.	"	Cel	uncate or	Dealli	2. Date of Death	g. No.	3. Time of Death
	Physicia /Medic		Delores N	10 Neil				Januar	Day Year	- 14 0 11
	Examin	2	4a. Facility Name (If not institution, give	street and number)	/ _ 1	4b. City, Town, o	r Location of Death		4c. County of Dea	2
			Bon Secont			Balt	more		N/A	
	Funeral Director		5. Social Security Number 6. Se 182–26–5671	X 7. Age (in)	vrs. last birthday) 70 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 01–14–193	Year) 9. Bir Lu Poor	thplace (State or Foreign ountry) ISylvania
	D		Usual Residence of Decedent					01 17 173	- Icu	isy ivailia
	arylan show	<u>-</u>	10a. State 10b. County MD NA	10c.	City, Town or Lo. Balti					10d. Inside City Limits 1X Yes 2 □ No
	the M	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	
	3a or		1613 Lemmon Street				223		USA	oundy:
	ems 2	Funerai	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent of H	dispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No-	14. Race - Ame	
36	within 72 hours after death with the Maryland iene. r then "natural", or Items 23a or 28e-f show the Medical Examinar mast be mutified at	by Fu	1X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X No If Yes, Give	1	1 ☐ Yes 2 🛣 No	Specify:	110411, 010.)	Specify: D1	
21215-0036	tural'		15. Decedent's Ed	Year or Dates:	16a, Dece	dent's Usual Occup	pation	1	6b. Kind of Business	
215	within 72 ene. than "na	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of working	ng i		
21	filed wit Hygiene other the	Соп	10			Cook				din Motor Inn
Maryland	d fail	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M ny Alexand		
Ž	2 should be and Mente Is marked sumatic e	우	Edward McNeil 19a. Informant's Name/Relationship (7)	vpe. Print)	19b. Mailii	na Address (Street	and Number or Rura			Zin Code)
	s 1 and 2 should I Health and Men Item 27 Is marke other traumatic		Ethel Parker/ Cousin	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			on St. Baltir		21223	Lip 0000)
Baltimore,	es 1 a of Hea f Item r othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	20	b. Place of Dispo	sition (Name of matory or other place	Ce) D	ate 2	0c. Location - City or	Town, State
ij	Pages Iment of I tant: If Its jury or o		* 4 ☐ Donation 5 ☐ Other (Specify) M	etro Crema		1-20-20	005	Catonsville,	, MD
Bai	permit. Pages Department of I Important: If It, any injury or o		21. Signature of Funeral Service Licens	Van a		2. Name and Addre Mylie Funera		N. Gilmor	Street Balti	imore, MD 21217
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	/Medical Examiner		resulting in death)	Due to (or as a con	1	Luke	100			201
		er	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b. Due to (or as a con	ratory sequence of	Jan 14			1 .	
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60,	lificate be executed g physician and as the burial-transit	ai Ex	resulting in death) Last	Dué to (or as a con	sequence of):					
68760,	icate physics the b	edicai		d		-				
Box (eath certii attending I for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		7E-A			23d. Date of de	livery
	e deatl he atte	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown		Ectopic pregnancy Other (specify)	/		Month	Day Year
P.0	that the de ed by the a detached		9 ☐ Unknown Part II. Other significant conditions or		resulting in the u	nderhing cause au	en in Part I	23a Did toha	ucco use contribute to	o the cause of death?
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eco	e law re has ber	ompieted			-			24a. Was an autopsy	24b. Were at	utopsy findings available completion of cause of
E E		Con						perform	ed? death? No 1 ☐ Yes	
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth	26. Place of Death			
of	g Phys er this ieral di): To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatier 28b. Time o	28c. Injur	y at 2	ne 5 Residen 8d. Describe hov	ce 6 Other (Spe	cify)
ion	Attending Ir death. ector: After	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) Injury	Wor	rk? Yes 2 □ No			
Division	l or Atte after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, str becify)	eet, factory, office	2	8f. Location (Stre City or Town,	eet and Number or Ri State)	ural Route Number,
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Medical C	29a. Certifier (Check only one) (Check only one) (Check only one)	sician: To the best of my iner: On the basis of exam	knowledge, deat nination and/or in	h occurred at the tir vestigation, in my o	me, date and place, a ppinion, death occurre	nd due to the cau	use(s) and manner as e and place, and due	s stated. to the cause(s)
	Fo the within ? To the comple	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number	29	d. Date signed (Mont	h, Day, Year)
		,	Amoton M.	Macen	mp	D	1550	3 7	nuary	122005
	7		30. Name and address of person who o	completed cause of death	(Item 23a) (Type,	Print)	hin =	Freat	Pelh	mp
B	Sta		31. Date filed (Month, Day, Year) JAN 2 1 200	31 Registrar's S	ignature	we /			7	21215
8	Registr	ar	CINIT N 1 200	2 July 1900	~ /-					

State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 18 200 **Physician** 6.15PM Resa 200 /Medical c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE NURSING CENTER CITY GOOD JAMARITAN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 214.54.5335 MARYLAND Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits in than "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director MD BALTIMORE KINGSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **U**SA DAYS WOOD 21087 7501 filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: WHITE 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) JEAMSTRESS **TEXTILES** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental is marked SOTTILE GIOVANDA LOGALISO MARIA ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21087 19a. Informant's Name/Relationship (Type, Print) ant. Pages 1 a. artment of Heatth. art: if Item 27 is. 7501 NOTO 20V KINGSVILLE, MD WALTER DAUS Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 2005 PRKVILLE, MD too Kwood 4 Donation 5 Other (Specify) ENTOW SMELL 21. Signature of Funeral Service Lisensee 22. Name and Address of Facility EVANS CHAPLL OF MEMORIES BBOO HARFORD RD. BALTIMORE, MD 21254 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ongo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown been signed the should be detected to the should be detected to the should be detected to the should be sh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s certificate has 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 2 ER/Outpatient 3 DOA of this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Hospital or Attending ospital c. 44 hours after dea. -ral Director: Afr 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai To the within 2 29b. Signature and title of certile 29c. License number pecacui 30. Name and address of pesson who completed cause of death (Item 23a) (Type, Print)
500 Loch Raver Blvd; Baltinele / Ild-5601 31. Date filed (Month, Day, Year) 32. Resstrar's Signature State 2005 Registrar

			4	artment of Health and Mental Hygiene tificate of Death Reg. No. 2005
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Alice Culbert Nettelbladt	2. Date of Death Month Day Year January 19 2005 9:00am
•	Examin	ner	4a. Facility Name (If not institution, give street and number) Golden Age Guest Home	4b. City, Town, or Location of Death Sykesville Carroll
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 17-07-8578 7. Age (In yrs. last birthday) 93 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Min. July 19 1911 Massachusetts
	Maryland t-f show	tor	10a. State 10b. County 10c. City, Town or Local	
	th with the 23a or 28e	Funeral Director	10e. Street and Number 1442 Buckhorn Road	10f. Zip Code 10g. Citizen of What Country? 21784 USA
2-003e	be filed within 72 hours after death with the Maryland hat lygiene. id other than "naturel", or items 23a or 28a-f show event, the Medical Eventiner must be notified at	by	1 3 X Widowed 4 □ Divorced If Yes, Give 1 Year or Dates:	Vas Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. □ Yes 2□No Specify: Specify: White
0-6171	filed within 72 ho Hygiene. Ither than "natur snt, Ine Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 16a. Decede (Give kille) Decede (Give kille) Of	lent's Usual Occupation kind of work done during most of working OC NOT use retired) ffice assistant clerical
_	2 should be filed and Mental Hygi Is marked other reumatic event, II	To Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame) Ada
s, Mar	and 2 sho ealth and m 27 is mu		Paul R. Nettelbladt (son) 19a. Informant's Name/Relationship (Type, Print) 5310 C	g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chase Lions Way, Columbia, Md 21044
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic a <u>once</u> .			y Cremation 1/21/2005 Sykesville, Md
Da	permi Depa Impo any ir		P.	Name and Address of Facility Haight Funeral Home & Chapel O. Box 195 Sykesville, Md 21784
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	Interval Between
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	
8/60,	cate be executed physician and the burial-transit	dicai	d	
O. BOX 6	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ E	Ectopic pregnancy 23d. Date of delivery Other (specify) Month Day Year
Records, P	equires that en signed b ould be deta	by	Part II. Other significant conditions contributing to death but not resulting in the unc	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
-	The law ate has b page 2 sl	Completed		24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
ा राखा	> .ºº 0	To Be	examiner? 1 Yes 2 No	, , , , , , , , , , , , , , , , , , ,
DIVISION	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	ertification:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 2 Accident investigation 3 Suicide 6 Could not be	28d. Injury at Work? M 1 Yes 2 No
2	spitel or A ours after nerel Direc filled in by	O		28f. Location (Street and Number or Rural Route Number, City or Town, State) occurred at the time, date and place, and due to the cause(s) and manner as stated.
	the Hos hin 24 h the Fur npletely	Medical		estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	T with	-	ratuck -	29c. License number 29d. Date signed (Month, Day, Year)
	`		30. Name and address of person who completed cause of death (Item 23a) (Type, PIATRICK TURNES 1000 LIBIR	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	
DH	MH 17 Rev 1/2	001	ORIGINAL	

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			For State Registrar	State of Marylar					ental Hygi	ene) nn	5 01412
_					C	ertificate (of L	Death	Re	g. No.	7 01415
	Dharainia		1. Decedent's Name (First, Middle, La						2. Date of Death Month		3. Time of Death
	Physicia /Medic		ANGELINE	DellA	No	ce				8 200	
	Examin		4a. Facility Name (If not institution, giv	e street and number)	,	4b. City, Tow	wn, or	Location of Death	<u> </u>	4c. County of	
			STELLA MARIS	Nursing H	one.	-	10	NUSON		BAL	LTIMORE
	Funeral		Social Security Number 6. S	ex 7. Age (In yrs.	last birtho		ear ays	If Under 24 Hrs. Hours Min.	8. Date of Birth		Birthplace (State or Foreign
	Director		215-09-9257	□M 30F 90	Yrs	i. World's Di	ays	Tiggis ioni.	8. Date of Birth (Month, Day, Nov 23	,1914	Country) MD
	g ,		Usual Residence of Decedent	10.0							
•	thow		10a. State 10b. County		ty, Town o						10d. Inside City Limits
E .	B Ma	cto	MO BAL	TIMORE		TOWSON					1 Yes 2 No
rd G	th th)ire	10e. Street and Number			10f. Zip Co			10	g. Citizen of Wha	
:10	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28e-f show the Medical Examinar must be notified at	Completed by Funeral Director	2300 DULANEY	VAILEY RD	•	0	21.	286		0.5	6. A.
3	r deg	Inel	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S.	 Was Decedent If Yes, specify 	t of His	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No-		American Indian, White, etc.
ထ္ထ	afte or it	币	1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give		1 □ Yes 2 ☑		Specify:	,	Specify:	vvino, do.
, S	urai',	Q p	2 Widowed 4 □ Divorced	Year or Dates:		, , ,				Specify.	WhiTe
2005 215-0036	72 t	ete	15. Decedent's En (Specify only highest gra	ducation de completed)	1 (0	ecedent's Usual O	one d	turing most of workit	19	6b. Kind of Busin	ness/Industry
2 2	Athin ne.	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	In	e. DO NOT use re	,			Hoi	A
2	led v lygie her t	ပ္ပ	12th	NIA		Homei					
18, land	be filed ital Hygi of other event, I	Be	17. Father's Name (First, Middle, Last,					18. Mother's Name			
JANUARY 18, altimore, Maryland		2		BINCIPID				GUIZEP.	PINA C	ARCA	NIA
ĭ	2 sho and is m		19a. Informant's Name/Relationship (and Number or Rura			
JANUARY more, Ma	and ealth m 27		Charles RAPI		112	20 BRO	oKi	vice was	1 Tows	en M	21286
N o	of H if its		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	Place of Di cemetery,	sposition (Name of crematory or other	of r place	e) , D	áte 2	Oc. Location - Ci	ty or Town, State
J.A.	permit. Pag Department Importent: i any injury o		*4 □ Donation 5 □ Other (Specif	y) Ito	14 B	edeemer	C	em /20	105	BAHZ.	M.
alt	permit. Departr Import any inj	ĺ	21. Signature of Funeral Service Licer	1500		22. Name and A	ddres	s of Facility	ILA QU	N-CRAI H	ome CHTD.
m	8 G E € 8		/ Dave Th	Stells		7527 h	asi	FURD RD.	Bolto 1	W 212	MA. Tome CHTD. 34
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat	th. Do not	enter the mode of	f dying	g, such as cardiac o	r respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final		nta n	There is a					Onset and Death
	/Medical		disease or condition resulting in death)	a. ALZHEIME							
	Examiner			10 (01	,-0.100 01)						
	s.p	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consec	uence of):						
	uted J ansit	Examiner	Cause (Disease or injury								
_	wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	xa	resulting in death) Last	Due to (or as a consec	uence of):						
760,	sicial buri	cai	(d							
387	phy:			0.							
×	certii Iding Ise a	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregna	ancv					22d Date o	of delivery
B	atter for u	clar	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	al death	3 ☐ Ectopic pregn 5 ☐ Other (specifi				23d. Date of Month	,
o.	he d the	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown	Joann	J Cities (specis)	·y/				
NGELINE Vital Records, P.O. Box 68	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	P	Part II. Other significant conditions of	ontributing to death but not res	sulting in th	e underlying caus	se dive	en in Part I.	23e. Did toba	acco use contribu	ute to the cause of death?
ds,	sign d be	d by		•		o and only mig	, c g c			s 2□No 3	
Ö	requ	Completed									
NE	25 2	npi							24a. Was an autopsy	prio	re autopsy findings available or to completion of cause of
그늘	The pag	S							perform		ith?] Yes 2 □ No
ANGELINE f Vital Rec	cian ertifi ector	Be	25. Was case referred to medical examiner?					26. Place of Death	(Check only one)	
AN O	Physician: this certificanal director,	၉	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpa	itient 3 DOA	Othe	4 Nursing Hon	ne 5 Resider	nce 6 Other	(Specify)
2 -	fter t	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Tim Inju	e of 28c.	Injury Work	at 2	8d. Describe how	w injury occurred	
DELLANOCE, Division	Attending r death.	Certification:	2 Accident investigatio			М	1 🗆 Y	res 2 □ No			
NA X	r Att	ţij.	3 Suicide 6 Could not be determined			, street, factory, of	ffice	2	28f. Location (Street, City or Town,	eet and Number State)	or Rural Route Number,
30	itaf c rs af raf D led ir	Cel						<u> </u>			
DE	Hospitafor 94 hours afte Funsraf Dirt tely filled in I	cai	29a. Certifier 1 Certifying Pt	ysician: To the best of my known the common the basis of examinations of examinations are the common than the common three	owledge, d	eath occurred at the	he tim	e, date and place, a	nd due to the car	use(s) and mann	er as stated.
		Medical	one)	and manner stated.							
	To the within To the comple	2	29b. Signature and title of certifier					number	29	d. Date signed (/	Month, Day, Year)
				-/0-			DI	43725		JANUARY	19, 2005
	6		30. Name and address of person who			pe, Print)			<u> </u>		
4	2		DR. TARIQ MAHMO	· · · · · · · · · · · · · · · · · · ·		VALLEY	RD,	TIMON	UM, MD	21093	
	Sta Registr		31. Date liled (Month, Day, Year) JAN 2 1	32. Registrar's Signat	ature	Some N.	,				

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			State of Maryla State of Maryla		rtment of Heatificate of De			one 005	01413
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) Freonite Pence 4a. Facility Name (If not institution, give street and number)	Det	4b. City, Town, or Lo		2. Date of Death Month	Dey Year 15 2-0 4c. County of Deal	
	Funeral Director	GI	Honard wanty General Ho	rs. last birthday) Yrs.	If Under 1 Year	6,4	3. Date of Birth (Month, Day, Y	Hous	hplace (State or Foreign untry)
	e Maryland Ba-f ahow tilfied at	ctor		City, Town or Loc Baltin					10d. Inside City Limits 1 X Yes 2 □ No
	th with th	Funeral Director	10e. Street and Number 1327 Gorsuch Ave.		10f. Zip Code 21218	8	10g	. Citizen of What Co USA	untry?
920	72 hours after death with the Maryland natural', or Itams 23a or 28a-f ahow ileal Examinet must be notified at	þ	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Was Decedent Ever in Amed Forces? 1 Wes 2 No lit Yes, Give Year or Dates:	If	Vas Decedent of Hispa Yes, specify Cuban, I	anic Origin? (Spec Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, White Specify: B	e, etc.
21215-0036	within iene.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade	(Give I life. D	ent's Usual Occupation kind of work done during NOT use retired)	on ing most of working	7	b. Kind of Business/ Domino Sug	Industry gar Refinery
Maryland	should be filed nd Mental Hygi marked other imatic event, II	To Be C	17. Father's Name (First, Middle, Last) Weldon Hunt	.er		3. Mother's Name (Ora	First, Middle, Ma	iden Sumame) Un	Known
	s 1 and 2 should I f Health and Meni item 27 Is marker other traumatic		19a. Informant's Name/Relationship (Type, Print) Sheila Pendleton Daughter		g Address (Street and W. Mulber:				Zip Code) 21223
Baltimore,	Pages 1 and of He Int: If item Int or other		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State	D. Place of Dispos cemetery, cremo	natory or other place)	1-22-C	20	c. Location - City or imonium, N	
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee		Name and Address of Aarch F.H.		Baltin 1101 E	more, Md. . North Av	21202 /e.
8760, U.	cate be executed whysician and physician and cate the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that indiated events resulting in death) Last Due to (or as a consider that indiated events resulting in death) Last Due to (or as a consider that indiated events resulting in death) Last	sequence of):	2.4	Dis 14			Approximate Interval Between Onset and Death
O. Box 6	that the death certifica led by the attending pt detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnant in the past 12 months? 4 □ Pregnant at time of 9 □ Unknown	etal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of deli Month	overy Day Year
rds, P.	sign d be	by	Part II. Other significant conditions contributing to death but not re	esulting in the un	derlying cause given i	in Part I.		co use contribute to	the cause of death?
Vital Records,	The law ate has b page 2 sl	e Completed					24a. Was an autopsy performe 1 Yes 2	prior to death?	topsy findings available completion of cause of 2 No
Division of Vit	ding Phys h. After this funeral dii	ertification: To Be	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		28c. Injury at Work? M 1 Yes	28 2 🗆 No	e 5 ☐ Residence d. Describe how	e 6 Other (Specinjury occurred	
Οįς	spital or ours afte eral Dir filled in I	O	4 Homicide determined 206. Face of injury Albuilding, etc. (Specare 29a. Certifier 1 Dentifying Physicien: To the best of my k	ecify)			City or Town, 5	State)	
	To the Hos within 24 h To the Fun completely	Medical	(Check only one) 2 Medical Exeminer: On the basis of examinand manner stated. 29b. Signature and title of certifier	nation and/or inv	estigation, in my opinio	on, death occurred	at the time, date	and place, and due Date signed (Month	to the cause(s)
)	11		30. Name and addies of person who completed cause of death (It	Hudin tem 23a) (Type, F	Print)	1320	7	7n 15	2005
	Sta Registr	3	31. Date filed (Month, Day, Year) JAN 2 1 2005 32 Aegistrar's Sig	o 57	st wh	14. C	olubir	+ md	21044

		State of Maryland / Department of 1- State Amend item#13, perFH, G839, 1/21 05 if Eate of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of Maryland / Department of 1- State of 1- St	Health and N		ne 005 01414
Physic	ian	Decedent's Name (First, Middle, Last) Lela Perry	Douth	2. Date of Death Month	Day Year 3. Time of Death
/Medi	cal	-	, or Location of Death	Jan. 15,	
Exami	iei	Sinai Hospital Bal	timore		N/A
Funeral Director		5. Social Security Number 6. Sex 1 M XXF 7. Age (In yrs. last birthday) 1 Yea Months Day		8. Date of Birth (Month, Day, You Feb. 27,	9. Birthplace (State or Foreign Country) 1915 Ohio
yland now		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	a 1.		10d. Inside City Limits
the Mar 28a-f sl	Director	MD N/A Baltimore 10e. Street and Number 10f. Zip Code		100	1 XXes 2 □ No Citizen of What Country?
ath with 23e or ust be		106. Street and Number 1539 South Charles Street	21230		USA
ite; INIGITY INITION AT A TONE STORY OF A TRANS A TRAN	y Funerai	1 Never Married 2 Married 1 Yes 2 Who	iban, Mexican, Puerto	pecify Yes or No- Pican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
2 hours	ted by	34_fW/Idowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occ	upation	168	b. Kind of Business/Industry
within 7 iene.	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemake	red)	ang	Own Home
yidilu yould be filed Mental Hyg Mental Hyg arked other	Be	17. Father's Name (First, Middle, Last) Unk.	18. Mother's Nam	e (First, Middle, Mai	iden Surname)
2 should be and Mental Is marked o	To	·	et and Number or Rur		ity or Town, State, Zip Code)
Tand 1 Health Hem 27 Sther tra		20a. Method of Disposition 20b. Place of Disposition (Name of			imore MD 21230 c. Location - City or Town, State
Deficiency Demit, Pages Department of Important: If if Into injury or of		1 □ Burial 2000 cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) Cemetery, ciematory or other pay Cemetery, ciematory or other pay BayView Crematory	· 1		altimore MD
Daltilliore, Mappenit, Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Fungrat Service ticensee Victor P. Doda, Jr. 22. Name and Add	ress of Facility Stevens Fund Ort Aveneu,	Home, I	inc.
TUNE S		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dy	ying, such as cardiac	or respiratory arrest,	Approximate
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.	we I'm	morrory	Onset and Death
Examiner	L		Tont	Dicea	25.
cuted id ansit	Examiner	if any, localing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
icate be executed physician and sthe burial-transit	ai Exa	resulting in death) Last Due to (or as a consequence of):			
rdifficate ing phys	Medicai	IF FEMALE:			
The faw requires that the death certification is the same signed by the attending ragge 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1	су		23d. Date of delivery Month Day Year
gned by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause g	iven in Part I.	23e. Did tobac	co use contribute to the cause of death?
w requires t				1 ☐ Yes	
The tav	Completed			24a. Was an autopsy performed	
ysicien: 'ysicien: 's certifica	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ № Hospital: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA ○		h (Check only one)	e 6 □Other (Specify)
ing Phy I. After this funeral d	ion: T	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury W. W.	ury at ork?	28d. Describe how i	
To the Hospitel or Attending Physicien: The law within 24 hours elter death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	Yes 2 No	28f. Location (Stree. City or Town, S.	t and Number or Rural Route Number, tate)
ospitel hours e unerel (29a. Certifier (Check only Medicel Exeminer: On the basis of examination and/or investigation, in my	time, date and place,	and due to the cause	e(s) and manner as stated.
To the H vithin 24 To the F complete	Medical	and manner stated.	nse number		Date signed (Month, Day, Year)
1			31464	i	1/20105
511		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHUAII3 A. HASIAMI, 82(N. ENTAW	ST Smt	205,	BALTIMORE MD 212
Sta Registi	_	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHUALIS A. HASIANI 82 (N. ENTAW) 31. Date filed (Month, Pay, Year) AN 2 1 2005 33 Registrar's Signature			

	1 - For State of Maryland	/ Department of Health and Mer Certificate of Death	ntal Hygiene
Physician /Medica	1. Decedent's Name (First, Middle, Last) Veronica R. Phillips	_	Date of Death Month Day Pear Inuary 18, 2005 3. Time of Death 5:40 P
Examiner	4a. Facility Name (If not institution, give street and number) Gilchrist Center for Hospice	4b. City, Town, or Location of Death TOWSON	4c. County of Death Baltimore
Funeral Director	5. Social Security Number 163-18-9319 1	Months Days Hours Min.	Date of Birth (Month, Day, Year) b. 4, 1917 9. Birthpiace (State or Foreign Country) Pennsylvania
with the Maryland to 7 28a-1 show be notified at	10a. State 10b. County 10c. City,	Town or Location icott City 10f. Zip Code	10d. Inside City Limits 1 ☐ Yes 2 ☒ No 10g. Citizen of What Country?
er death v	3489 N. Chatham Road 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	21042 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 □ Yes 2 ☒ No Specify:	USA Yes or No- 14. Race - American Indian,
Maryland 21215-0036 d 2 should be filled within 72 hours aft th and Mental Hygiene. "Tale marked other then "naturel", or traumatic event, the Medical Entitle To Re Completed by E	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Vland 2: Montal Hygie Arite other introduced the count. Entitle Count.	17. Father's Name (First, Middle, Last)	Homemaker 18. Mother's Name (Fit Mary Trza	Own Home irst, Middle, Maiden Surname) BSkawka
imore, N Pages 1 and ment of Health ant: If then 27 ury or other tr	19a. Informant's Name/Relationship (Type, Print) Susan Puglese Daughter 20a. Method of Disposition 1 Burial 2 M Cremation 3 Removal from State	19b. Mailing Address (Street and Number or Rural Rolling Address) 1520 kidgewood Koad; Ye co of Disposition (Name of Date Date Date) imore—Wash.Crem. 1/25/20	oute Number, City or Town, State, Zip Code) 17402 20c. Location - City or Town, State 205 Laurel, Maryland
Balt permit. Departr Imports any inji	21. Signatore of Funeral Service Licensee	730 Edilondson Avenue	vab Funeral Home, Inc. e; Catonsville, MD 21228
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ringiny)	Aire heart Sail	spiratory arrest, Approximate Interval Between Onset and Death Jean
S8760, cate be executed physician and it the buriat-transit	resulting in death) Last C. Due to (or as a conseque	nce of):	
O. Box 6 O. Box 6 the attending the attending ched for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown 23c. If yes, outcome of pregnant 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea	eath 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
S # se bed bed	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
OI - 18 I Rec The law cate hes b	Jenenter		24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 2 No 2 No
of Vital of Vital Physician: This certificate ral director, pc	examiner?	26. Place of Death (Cl 26. Place of Death (Cl 27. Place of Death (Cl 26. Place of Death (Cl 27. Place of Death (Cl	heck only one) 5 ☐ Residence 6 #Other (Specify) (-
Son Sting	Thinpation 2021		Describe how injury occurred
Division of Division of To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.			Location (Street and Number or Rural Route Number, City or Town, State)
Div Div To the Hospital or within 24 hours afte To the Funerel Div compietely filled in to	and manner stated.	edge, death occurred at the time, date and place, and n and/or investigation, in my opinion, death occurred a 29c. License number	due to the cause(s) and manner as stated. It the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)
● F3F8	30. Name and address of person who completed cause of death (Item 2	D25205	JANUARY 19, 2005
State	W.A.Riley 6BMC 6701	N. Charles St. Ba	Cta. Md 2,204

				State of Maryland / Dep		•	•
			1 - State Registrar		rtificate of Death	-	eg. No. 2005 01416
	Physic	20	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	Day Year
	/Medi			Pappas		January	
	Examir	ner	4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Dea Rockville	th	4c. County of Death Montgomery
	Euperol		Casey House 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)		s. 8. Date of Birth	
	Funeral Director			M 2□F 47 Yrs.	Months Days Hours Mir		Country) 5, 1957 Washington, D.(
	nyland how		10a. State 10b. County	10c. City, Town or Le	ocation		10d. Inside City Limits
	the Marylar 28e-f show	cto	Maryland Montgomer	y Germantow	m		1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number	Design #1/	10f. Zip Code	1	log. Citizen of What Country?
	eath	erai	19623 Crystal Rock		20874 Was Decedent of Hispanic Origin?	Specify Yes or No-	USA 14. Race - American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or items 23a or 28e-1 show any injury or other treumatic event, Its Madical Examinat. Just be notified at sonce.	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ∐ Yes 2. No If Yes, Give	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2X No Specify:	rto Rican, etc.)	0 4
8	hour turel	ed b	15. Decedent's Educ	Year or Dates:	dent's Usual Occupation		willte
15	n "ne	piet	(Specify only highest grade	completed) (Give	o kind of work done during most of w DO NOT use retired)	orking	16b. Kind of Business/Industry
21215-0036	12 should be fitted within "h and Mental Hygiene." I'll marked other than "reumatic event, It. Max.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) Mecha	nical Technician		Housing
	al Hy d oth	Be (17. Father's Name (First, Middle, Last)			ame (First, Middle,	•
yla	ould to Ment arked	2	Ronald Jay Weiss		Marilyn	Sue Bail	Ley
Maryland	12 sh h and 7 Is rr treurr		19a. Informant's Name/Relationship (Typ		ing Address (Street and Number or F		
	1 and Health em 27		Beth Diane Jenkins 20a. Method of Disposition				3 Germantown, MD 20874 20c. Location - City or Town, State
<u>0</u>	Pages nent of int: If it		1 ☐ Burial 2X Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)		matory or other place) Jan el Crematory	uary 21, 2005	Odenton, Maryland
Baltimore,	permit. F Departme Importer any injur		21. Signature of Funeral Service License	1	- 1	-	
m	Depa Impo any ir		Beverly L. H.	MO1251 Be	verly L. Heckrot	te, F.A.	ce P.O. Box 784 Clarksville, 10 21029
	Physician /Medical Examiner	Examiner	shock, or heart failure. List only on the timediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			Interval Between Onset and Death
3760,	ate be nysicii he bu	icai	d				
.O. Box 68	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the buriat-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	that the	Phy	Part II. Other significant conditions con	tributing to death but not resulting in the I	underlying cause given in Part I	23e. Did to	bacco use contribute to the cause of death?
Records,	w requires t been signe should be	ed by				1 🗆 Y	77
eco	law requ as been 2 shoule	Completed				24a. Was a	prior to completion of cause of
	(Q L	Con				perform	med? death? 2X No 1 Yes 2 No
/ita	Physicien: The law this certificate has be ral director, page 2 s	Be	25. Was case referred to medical examiner?	ospital:		ath (Check only or	
of Vital	Phys this ral dir	L.	1 ☐ Yes 2 🛣 No	1 ☐ Inpatient 2 ☐ ER/Outpatien 28a. Date of Injury 28b. Time of			ence 6 XOther (Specify) Hospice
on	Attending F r death. sctor: After by the funer	tion	1 Avatural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	of 28c. Injury at Work? M 1 Yes 2 No	200. Describe in	ow inquity occurred
Division	r Attendi er death. rector: A by the fu	Certification:	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Si City or Town	treet and Number or Rural Route Number,
Ō	itel or ars after rel Dii	Cer		Danamy, oto. (opeany)		0.1, 0.7 7 0.11	, classy
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) Certifying Phys Certifying Phys Check only one)	ician: To the best of my knowledge, deal er: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place average in the convertigation, in my opinion, death occurred.	e, and due to the curred at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)
	within To the	Me	29b. Signature and title of certifier		29c. License number	2	9d. Date signed (Month, Day, Year)
	Λ		Call !!		041218	-	01/20/05
	1		30. Name and address of person who co	mpteted cause of death (Item 23a) (Type			
			Charles Harrison M.	D. 6001 Muncaster	Mill Rd. Rockvil	le, MD 20	855
	St Regist	ate rar	31. Date filed (Month, Day, Year) JAN 2 1 2005	32. Registrar's Signature	()		

			1 - State Amjend Item Registrar	State of Maryl 19a per info	and / Dep rmant C	artmer 340 rtlfica	nt of He -10-0 te of D	alth and tas eath	Mental Hy	giene Reg. No. 2	005 0	141
	Physici /Medic			PASSLEY					2. Date of De Month	My 17	ZOOJ Y	e of Death
	Examin	er	4a. Facility Name (If not institution, give FUTURE (ARE 5. Social Security Number 6. Se	OLDCOURT	N H	RA	WOAL	Cation of Deal	V	SAL	ty of Death	
	Funeral Director			□ M 2K□ F 86	V	Months		Hours Min.	(Month, Da	17, Year) 1 18	9. Birthplace (Sta Country) Jamai	_
	death with the Maryland ms 23a or 28a-f show rmust be notified at	tor	10a. State 10b. County MD NA		City, Town or Lo							le City Limits Yes 2 ☐ No
	th with the M 23s or 28s-f	i Director	10e. Street and Number) - -	*** *	10f. Zi	p Code	07			What Country?	
920	hours after death tural', or Items 2 al Examente mus	by Funeral	6718 Brompton F 11. Marital Status 1 Never Married 2 Married **Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	i		_		Specify Yes or No to Rican, etc.)		S.A. Ice - American India ack, White, etc. ify: Black	n,
21215-0036	n 72 "na"	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Give	kind of w	ual Occupation ork done dur use retired)	on ing most of wo	rking	16b. Kind of I	Business/Industry	
nd 21	be filed withital Hygiene. d other than	Be	12th grade 17. Father's Name (First, Middle, Last)	lyr	<u> </u>	lair	Dres		me (First, Middle		nuty Sal	on
Maryland	2 should and Men is marke aumatic	၉	Felix McCain 19a. Informant's Name/Relationship (7 Merle Spencer	Type, Print)				d Number or Ri		er, City or Town	n, State, Zip Code)	
Baltimore, N	0 0		Merele Spencer = 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	-Daughter Removal from State	b. Place of Dispo cemetery, cre	osition (Na matory or	me of other place)		Balt Date	20c. Location	- City or Town, Stat	
Baltir	permit. Pag Department Important: t any Injury o		21. Signature of Funeral Service Licen	C Aum	. / M	larch	r/H	West	24/05 Balt		Md 21	Md 215
	Physician /Medical		23a. Part1. Enter the disease, or compended, or heart failure. List only disease or condition resulting in death)	a	eath. Do not en	ter the mod	de of dying,	such as cardia	c or respiratory a	rrest,	Approx	
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a condition of the cond	U	T	Ī.					
8760,	ate be executed hysician and the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a cons	sequence of):							
P.O. Box 68	ne death certific the attending p hed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of	etal death 3	⊒Ectopic p ⊒ Other (s)					ate of delivery onth Day	Year
	w requires that the bean signed by should be detact	þ	Part II. Other significent conditions of	ontributing to death but not	resulting in the u	inderlying (cause given	in Part I.		obacco use cor Yes 2 □ No	atribute to the cause	of death?
Division of Vital Records,	The law ate has b page 2 sl	Completed							24a. Was autor perio 1 🗆 Yes		Were autopsy finding prior to completion death? 1 Yes No	ngs available of cause of
Vita	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient 2	2 ☐ ER/Outpatier	nt 3 D	Other		ath <i>(Check only c</i> fome 5□ Resid		her (Specify)	
ion of	fte fte ine		27. Manner of Death Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year			28c. Injury at Work?		28d. Describe I			
Divis	s after des s after des al Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	at home, farm, str ecify)	reet, factor	y, office	•	28f. Location (S City or Tox		ber or Rural Route I	Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier (Check only one) Certifying Phrace 2 → Medicel Exemption	ysicien: To the best of my ilner: On the basis of exam and manner stated.	knowledge, deat nination and/or in	h occurred ivestigation	at the time, n, in my opin	date and place ion, death occu	a, and due to the urred at the time,	cause(s) and m date and place,	anner as stated. , and due to the cau	se(s)
	To the within 2 To the complei	×	29b. Signature and title of certifier	un los		29	c. License n	umber 7335	2	_	ed (Month, Day, Yea	
1	for.		30. Name and address of person who dead with the control of the co	D. 5400	old Co	Print) URT	M,	Mp2	1133			
	Sta Registr	-	31. Date filed (Month, Day, Year) JAN 2 1 2	32. Pagistrar's Si	gnature	best	j					

		= State Registrar		-	artment of H rtificate of			g. No. 20	05	0141
Physicia /Medic		1. Decedent's Name (First, Middle, I Yetta		arks			2. Date of Death Month January		005	3. Time of Death 7:10 p
Examin		4a. Facility Name (If not institution, g Crofton Conval		er	4b. City, Town, o	r Location of Death		4c. County Anne		e1
Funeral Director		229-32-5967	Sex 7. Age 1 M 2 F	76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 23			ce (State or Foreig
e Maryland Ba-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Anne A	rundel	10c. City, Town or Lo					100	d. Inside City Limits
i within 72 hours after death with the Maryland jene. jene. rthan "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at	Funeral Director	10e. Street and Number 940 Fall Ridge 11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent I Armed Forces? 1 Yes 2X	lo		lispanic Origin? (Spe an, Mexican, Puerto			e - Americai k, White, et	n Indian,
d 2 should be filed within 72 hours all dand Mental Hygiene. 77 la marked other than "natural", or traumatic avent, the Medical Eram	Completed by	3XWidowed 4 □ Divorced 15. Decedent's (Specify only highest of		16a, Dece	dent's Usual Occur		ng 1	Specify 6b. Kind of Bu		ite
be filed within tal Hygiene. Id other than " avent, IL Me.	Ве Сотр	Elementary/Secondary (0·12) 12 17. Father's Name (First, Middle, La	College (1-4or 5	+)	maker	18. Mother's Name		Own H		
d 2 should be th and Mental 7 Is marked of traumatic av	ToB	Carlis Woods 19a. Informant's Name/Relationship		19b. Maili	ng Address (Street	Ella M and Number or Rura	lae Willi I Route Number,		State, Zip C	Code)
es 1 an of Heal of Heal fitem?	1	Carl Richardson 20a. Method of Disposition 1 □ Burial 2XXCremation 3 4 □ Donation 5 □ Other (Spe	☐Removal from State	940 20b. Place of Dispo cemetery, cree Metro Cr	sition (Name of matory or other plac	ge Way, Ga	ate 20	MD 21 Oc. Location - Baltimo	City or Tow	
permit. Pag Department Importent; I any injury o		21. Signature of Funeral Service Ide			Name and Addre Hardesty	-	Home, P.	Α.		
Physician /Medical	51 1	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each lir	e. Ø					1	Approximate interval Between Dinset and Death
Ite be executed ysician and burial-transit	ical Ex	Sequentially list conditions, any bacing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C.	a consequence of):	hagi u	n dec	idat			1 year
The law requires that the death certification has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ December 2 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy	1		23d. Date Mon	of delivery	ay Year
w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	nderlying cause giv	en in Part I.				cause of death?
	Completed						24a. Was an autopsy performe	ed? p	Vere autops rior to comp eath?	y findings available bletion of cause of
Attending Physician: T rdeath. sctor: After this certificat by the funeral director, ps	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 16 27. Manner of Death 1 Matural 5 Pending investigat	28a. Date of Injur (Month, Da)		28c. Injur Wor	y at 2	(Check only one) ne 5 ☐ Residen 28d. Describe how	ce 6 □Othe		
in Sir e	Certification:	3 Suicide 6 Could not determine	building, etc			1	28f. Location (Stre City or Town,	State)		
To the Hospital or At within 24 hours after of To the Funeral Direc completely filled in by	Medical	one) 2 Medicel Ex	Physician: To the best of eminer: On the basis of and manner sta	examination and/or in	vestigation, in my o	pinion, death occurre	ed at the time, date	e and place, a	nd due to th	ne cause(s)
T with	Σ	29b. Signature and title of certifier	Ply	mo		35848		d. Date signed	2/0	05
10		30. Na e and address of perso when the state of the state	H2 1438	eath (Item 23a) (Type, Perfect 5 Ir's Signature	Print) Hug	Gamb	nills h	11/21	050	

				Department of Health and Mental H	Hygiene 2005 01419
_			Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No. Death 3. Time of Death
	Physicia		JUAN: M. PERRY	Month,	- 16 2005 2120
	/Medic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			GOOD SAMARITAN HOSP. TA		NIA
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bin $1064 - 18 - 3632$	htday) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. Month,	Birth Day, Year) 30, 193 4 9. Birthplace (State or Foreign Country) V. J.
-			Usual Residence of Decedent		
	arylan show	ž	10a. State 10b. County 10c. City, Town	BALTIMORE	10d. Inside Øity Limits 1 ☑ Yes 2 ☐ No
	the Marylar 28a-f show	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	within 72 hours after death with the Maryland ene. Then "neturel", or tems 23e or 28e-f show the Medical Examinar must to mailfled at		3025 OAKCEEST AVE.	21234	U.S.A.
	ems 2	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
20	s after	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Gire 9	1 ☐ Yes 2 ☑ No Specify:	Specify: Lik (Te
3-003p	2 hour	edb	15. Decedent's Education 16a.	Decedent's Usual Occupation	16b. Kind of Business/Industry
2 2	thin 72 e. en "ne Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	11
N	filed wi Hygien Sther th			Clothin 6 Buyer 18. Mother's Name (First, Mid	HUTZlers Store
	d la d	Be c	17. Father's Name (First, Middle, Last) CLAUDE Bell	1 ^) nknown
3	should land Men s marke	7		Mailing Address (Street and Number or Rural Route Num	
	s 1 and 2 f Health a item 27 is other tre				MD 21234
ore ore				Disposition (Name of y, crematory or other place)	20c. Location - City or Town, State Balto (W),
altimore,			'4 □Donation 5□Other (Specify) 21. Signatur of Funeral Jervice Licensee		
ğ	permit. Departr Import eny inj		Jane M. Stelle	22. Name and Address of Facility Stella F HARTICY MILLOR-STELLA F 75-27 harfold RD Bal-	6.NS 21834
			23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or hear failure. List only one cause on each line.		y arrest, Approximate Interval Between
-01	Pnysician		Immediate Cause (Final disease or condition resulting in death)	5HOCK	Onset and Death
	/Medical Examiner		Due to (or as a consequence of	RAL PNEUM	Calia
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	of).	210111
	cuted nd ransit	Examin	that initiated events	ED ULCERS	
/60,	be execute sician and burial-trans		resulting in death) Last Due to (or as a consequence of	of):	
289	ate hys	edicai	d		
×	leath certific attending p	M/ut	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Feital death	3 □Ectopic pregnancy	23d. Date of delivery
O.	at the deat by the att	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 ∰ Mrknown in the past 12 months? 4 □ Pregnant at time of death 9 □ Unknown	5 Other (specify)	Month Day Year
٦.	that the		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I. 23e. D	id tobacco use contribute to the cause of death?
ecords,	The law requires that the tee has been signed by the bage 2 should be detache	d by	END STAGE RENA	L DISEASE 1	☐ Yes 2☐ No 3☐ Probably 4 ☐ Unknown
S S	aw require ts been si 2 should b	plete	RHEUMATOID AR	THRITIS 24a. W	/as an 24b. Were autopsy findings available prior to completion of cause of
<u> </u>		Completed	Type II Diabetes	mellitus 10 Ye	erformed? death?
Vital	Physicien: r this certific ral director.	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Check on	
ō	L ha): To	27. Manner of Death 28a. Date of Injury 28b. T	Firme of 28c. Injury at 28d. Descrit	esidence 6 Other (Specify) be how injury occurred
0	Attending F death. ctor: After y the funera	atio	2 Accident investigation	njury Work? M 1 Tyes 2 No	
Division of	of or Attend after death Director: /	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)		n (Street and Number or Rural Route Number, Town, State)
	pitel ours all	i Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge	e, death occurred at the time, date and place, and due to t	the cause(s) and manner as stated
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Medical	(Check only one) 2 Medicel Exeminer: On the basis of examination and manner stated.		
	To th To th comp	Me	29b. Signature and title of certifie	29c. License number	29d. Date signed (Month, Day, Year)
,	<i>(</i>		Vereberg M. D		January 16, 2005
	り		30. Name and address of person who completed cause of death (Item 23a)		BLVD BALTIMORE
	Sta	te	31. Date filed (Month, Day, Year) 32. Restrar's Signature		- Districted
	Registi	ar	JAN 2 1 2005 Men &	specie	

DHMH 17 Rev 1/2001

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			1 - For Amend Item	25 State of	f Marylan ie G841	13-9-05 Ce	artment of tas	of He <i>of D</i>	ealth and <i>eath</i>	Mental Hy	giene	05	01420
			1. Decedent's Name (First, Middle,	,						2. Date of De	aath		3. Time of Death
	Physici		CALVIN	OGER		QU	EEN			JAN	Day	Year	5:21 PM
	/Medio Examin		4a. Fecility Name (If not institution,	give street and nu	ımber)		4b. City, To	wn, or L	ocation of Dea		1	y of Death	
			HARBOR HOSPIT	AL CEN	TER		BAL	TIA	YORE				
	Funeral		5. Social Security Number	. Sex	7. Age (In yrs.	last birthday)		Year Days	If Under 24 Hr Hours Mir		rth av. Year)	9. Birthp	place (State or Foreign
	Director		234-84-3754	1 ∑ M 2□F	53	Yrs.	NOTICIS	Juys	110013	JULY 1	7, 1951	Wes	sť Virginia
_	pu *		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ocation					11	Od. Inside City Limits
	sho sho	ō	MD			imore	70211011					,	1√E Yes 2 □ No
	the A	Director	10e. Street and Number		Dail	люте	10f. Zip Co	ode			10g. Citizen of	What Cour	
	filed within 72 hours after death with the Maryland Hygiene. Ither than "naturel", or Itams 23a or 28a-f show ent, tre Manical Examirer must be notified at	<u>=</u>	610 Church St	reet				21225	ō		US		y.
	ms 2;	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Deceden	nt of Hisp	panic Origin? (Specify Yes or No		ce - Americ	
ထ	after or ita		1 Never Married 2 ☐ Marrie	Armed F	orces? ^{2□No} Arπ	** 7				erto Rican, etc.)		ick, White,	etc.
83	ral', c	l by	3 Widowed 4 Divorced	Year or E	Dates: 1968-	-70	1 ☐ Yes 2万	1 NO	Specify:		Specia	ην: wh	ite
5-0	72 hours "natural",	Completed	15. Decedent's (Specify only highest)	(Give	dent's Usual E	done dui	on ring most of w	orking	16b. Kind of E	Business/In	dustry
7	Athin han	du	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use	,	_		Trade		-
2	iled v tygie har t		12 17. Father's Name (First, Middle, L.	pet)		Car	penter		9 Mothar's N	ame (First, Middle	Self-E		ea
anc	be f and life and of	Be						'				1110)	
<u> </u>	d Me mark matic	2	Julius W. Queen			10h Mailir	ng Address /S	Stroot an		P. Dolar. Rural Route Numb		State 7in	Code
<u>_</u>	d 2 s th an th an trau		Catherine Paint		end					ltimore,		, 31a16, 21b 225	C00e/
نه	1 an Heal Heal		20a. Method of Disposition				osition (Name matory or othe			Date	20c. Location		own, State
Baltimore, Maryland 21215-0036	ages ant of t: If if		1 Burial 2 □ Cremation 3		State Gas	semetery, crei	matory or othe ≥nry−Qu	er place) 1 een	1/2	21/2005	Weston	. Wes	t Virginia
連	artme ortan injur		21. Signature of Funeral Service Li			Came	toru		i	•			_
a	permit. Pages 1 and 2 should be filed within 72 h Dep. timent of Health and Mental Hygisne. Important: if item 27 is marked other than "natu any injury or other traumatic event, Ite M. dica	Ŀ,) Mc V	Hadev	nan	Ga 72	ary L.	Kaui	fman'Fu	neral Ho Lvd., Elk	me@Mea	.dowri	dge MP Inc.
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that	caused the deat							MD Z	Approximate
	- Commission		Immediate Cause (Final										Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)		Or as a conseq		ATOR	4 6	FAILUI	25			30 HOYRS
	Examiner				T BAS		ANGLI	Α	INTRA	CEREBR	AL HE		30 Hours.
		Jer	Sequentially list conditions, if any, leading to immediate		(o. as a conseq		111-1-1	1	17-11-14	00,100	1,0	(O James)	AFTE
X	cuted nd ransi	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	o. 44	PERTEN	SIVE	EME	RHE	NCY.				
, o	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to	(or as a conseq	uence of):					11/1		
68760	physic ptysic the bu	dlcal		d					-0		Want.	-	
		Med	IF FEMALE:						7	APER WED SYMM	יוֹי		
Вох	w requires that the death certifuence of the strending been signed by the attending should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	itcome of pregna birth 2 ☐ Feta	I death 3	∃Ectopic preg		CERTIFICATION	1	23d. Da	ate of delive	ery Day Year
()	e death the atten ned for u	slcl	1 Tes 2 No 9 Unknown	4☐ Preg 9☐ Unkr	nant at time of d	leath 5	Other (speci	rfy)		<u> </u>	, , ,	OTTET	Day rear
2 9	d by	P.	Part II. Other significant condition	e contributing to	looth but not roc	ulting in the u	ndorhing onu		in Part I	23a Did	tahansa usa san	tributa ta th	ne cause of death?
35	res the signer libe of		SUBSTAN	_		uning in the u	nuenying cau:	se diveri	in raiti.		,		ably 4 Dunknown
A oro	requ	etec											
of Vital Records.	e law has t	Completed	END - STAC	ERE	NALI	DISE A.	32			24a. Was	an 24b. psy prmed?	Were auto	psy findings available mpletion of cause of
13 4	: Th									1□ Yes	2 No	1 Yes	2 No
Vit.	ysician: The la is certificate had director, page 2	Be	25. Was case referred to medical examiner?	Hospital:	,					eath (Check only		-	
2 5	Phys this	- To	1 Yes 2 No	1 62	Inpatient 2	ER/Outpatier 28b. Time of		Inuar a	4 Nursing	Home 5 Resi	dence 6 Oth		/)
3 5	ding After funer	lol	1 Natural 5 ☐ Pending		of Injury oth, Day Year)	Injury	М	Unjury a Work?	s 2 □ No	200. D030100	now injury occur	1160	
tale	deatl deatl ctor: y the	flca	3 Suicide 6 Could no	t ho	e of Injury - At he	ome, farm, str				28f. Location (Street and Numi	ber or Rura	i Route Number.
W S	al or Attending Physis after death. In Diractor: After this coding the funeral directions.	Certification:	4 Homicide determin	build	e of Injury - At he ling, etc. (Specif	(y)	,,,			City or Tò	wn, State)		
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To tha Funaral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier 1 Certifying	Physician: To th	e best of my kno	wledge, deat	h occurred at 1	the time,	, date and plac	ce, and due to the	cause(s) and m	anner as st	ated.
Ų.	ne Ho 124 h na Fu iletely	edical	(Check only 2 Medical E	kaminer: On the b	pasis of examina nner stated.	ition and/or in	vestigation, in	my opir	nion, death occ	curred at the time,	date and place,	and due to	the cause(s)
	withir To the	×	29b. Signature and title of certifier					icense r	number		29d. Date signe	d (Month,	Day, Year)
			1 Katheren Si	,					000		JANHAR	4 17	1 2005
	, 7	+	30. Name and address of person w	ho completed cau	se of death (Iten	n 23a) (Type,	Print)						
_			Kathleen S	terbis	24	21 K	repps	We-	7 00	denton,	MD 2	1113.	
	Sta		31. Date filed (Month, Day, Year)	32. 1	Redistrar's Signa	ature /	book	•		denton			
	Regist	rar	IAN 2]	2005	CE COLOR	~ /							

	•	1 - For Stata Registrar	State of I		Ce	rtificate	e of L	Death			Rag. No	/ 11	05	0 4
Physicia /Medic		1. Decedent's Name (First, Middle, L LEROY	JOSEPH		RUEH	L				2. Date of De Month JANUA	Da	ğ 20	Ŏ5	3. Time of Dea 12:15 A
Examin	er	4a. Facility Name (If not institution, g GENESIS HAMMONI 5. Social Security Number 6.	OS LANE		la at historia.	BROO	OKLYI	Location of PAR	K		A		ARUN	DEL CO.
Funeral Director		215-05-1088 Usual Residence of Decedent	.Sex 7. 107 M 2□F	96	. last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bi	^{ay} 1 908	3	9. Birth Cou Mar	place (State or Foi intry) y Land
e-f ehow	ctor	10a. State 10b. County Maryland N/	A	10c. Ci	ity, Town or Lo			-						10d. Inside City Lin
3a or 28 at the no	I Dire	10e. Street and Number 11 W. West Str	eet			10f. Zip		230			10g. Cit	U.S	What Cou	ntry?
Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23a or 28e-f ehow any injury or other traumatic event. If a Medical Ever ill at must be notified at once.	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 MYes 2 [If Yes, Give Year or Date	es?		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)	0-	14. Race Blace		
ene. then "neture fre Medical E	ompleted	15. Decedent's (Specify only highest g	Education		16a. Dece (Give life.	dent's Usual kind of won DO NOT use	rk done di se retired)	urina most	of working	ng		ind of Bu		,
h and Mental Hygiene. 7 Is marked other then "r fraumatic event, I'et Med	To Be Co	17. Father's Name (First, Middle, Las	F. Rue	ehl				Lou	iisa		, Maiden	Sumam	e)	
alth and		19a. Informant's Name/Relationship Anna LaMonte	(Type, Print) (Sister)		19b. Mailir 1224	Address Sout	(Street a	nd Numbe arles	rorRuma SStr	Route Numb	er, City o Balti	nr Town, s .more	State, Zip	code) 212 aryland
ant of He it: If item y or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	☐Removal from Sta	ite	Place of Dispo cemetery, crer ew Cath	matory`or oti	ther place		ס -21−	ate -0.5			•	own, State Maryland
Departme Importan any injur once.	1	21. Signature of Ferreral Service Lice		,										21230 yland
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	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
G	/Medi		Louise H.	Robinson	January	[□] 1 20 0 5	8:20a. M
	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
_	F		8900 Grummore Circle 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Pikesville If Under 1 Year If Under 24 Hrs.	9 Date of Ridh	Balti	
	Funeral Director		204-24-6138 1 M 2 N F 73 Yrs.	Months Days Hours Min	8. Date of Birth (Month, Day, Y		place (State or Foreign ntry) PA
	pu ,		Usual Residence of Decedent		01 30	J1 .	· A
	laryla shov	۲	10a. State 10b. County 10c. City, Town or				10d. Inside City Limits
	the N	Director	MD Baltimore Pil	cesville	10.		1 ☐ Yes 21 No
	3a or	0		10f. Zip Code	lug	. Citizen of What Cou	ntry?
	ms 2	Funeral	8900 Grummore Circle 11. Marital Status 12. Was Decedent Ever in U.S. 1	21208 3. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	U.S.A.	can Indian.
ထ္	or ita	Ful	1 ☐ Never Married 2 🕅 Married	If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	Rican, etc.)	Black, White,	etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or itams 23a or 28a-1 show int. The Medical Examinational be multified at	d by	3 Wildowed 4 Divorced Year or Dates:			Specify: B.	lack
7	n 72 n	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of worki b. DO NOT use retired)	ing 161	b. Kind of Business/In	dustry
712	with iene. r thar	ошр	College (1-40r 5+)	Clerical		.S. Gove	rnment
	e filec other vant.	BeC	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai		
/lar	should be ind Mental markad o	ToE	Harvey Wright	Maude J	Jackson		
Maryland	C) (0 - 00			iling Address (Street and Number or Rura	al Route Number, C	ity or Town, State, Zip	Code)
	1 and Health Iam 27 other tr			Grummore Circl	-	-1	
more,	Pages I nent of H int: If its iry or ot		222 Communication of Cartamoral Foundation	position (Name of Ematory or other place)	Date 200	c. Location - City or To	wn, State
ᄩ	permit. Page Department of Important: If any injury or once.		` 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		05 P	ikesvill	e, Md
Ba	Depril Impo		TOTO I	22. Name and Address of Facility March F/H West	Daltin	EM core	21215
			23a. Part1. Enter the disease, or complications that caused the death. Do not e	1300 Wabash Ave , onter the mode of dying, such as cardiac of		ore, Ma	21215 Approximate
	Physician		Immediate Cause (Final				Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Thulluoluo Due to (or as a consequence of):	1 21			
	Examiner		Sequentially list conditions h Carcino C	olon stage	11		
	si ad	Examiner	Sequentially list conditions, if any, leading to firm ediate cause. Enter Underlying Cause (Disease or injury	0			
	and and Il-tran	хаш	that initiated events resulting in death) Last C				
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89	death certificate be executed e attending physician and id for use as the burial-transit	edic	d				
Вох	leath certific attending p	M/u	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3			23d. Date of delive	нгу
E	ed for	sicle	1 Yes 2 No 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
у О	at the ded by the setached	Physician/Me	9 LI ONKNOWN				
က်	The law requires that the te has been signed by the age 2 should be detache	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to th	
Ö	w requir been si should I	eted	Tig per custon		1 🗌 Yes	2 No 3 Prob.	ably 4 Unknown
Kecords,	has l	Completed	01		24a. Was an autopsy performed	prior to con	psy findings available appletion of cause of
	. 48 52	e Co	25. Was case referred to medical		1 Yes 2		2□ No
5	Phyaician: this certific ral director,	0 8	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient	26. Place of Death ent 3 DOA Cther: 4 Nursing Hom		- Mileul	1 Home
Ö	ding Phy h. After thi funeral	L.	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c, Injury at 2	8d. Describe how in	njury occurred)
0.5	tending lasth. tor: After the funer	atio	2 Accident investigation N.A	M 1 Yes 2 No			
DIVISION	of or Attending F safter death. I Diractor: After I by the funera	ertification;	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 2	8f. Location (Street City or Town, St	and Number or Rural	Route Number,
_	pital o	O					
	Hoa 24 ho Fun etely f	edical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea (Check only one) 1	th occurred at the time, date and place, a nvestigation, in my opinion, death occurre	nd due to the cause od at the time, date a	o(s) and manner as sta and place, and due to	ited. the cause(s)
	To the Hospital or Atten within 24 hours after deat To the Funaral Director: completely filled in by the	Me	26b. Signature and title of certifier	29c. License number	29d. I	Date signed (Month, L	Day, Year)
-		1	Dale willer Mi	DUS783	3 1.	20.00	>
1	11		30. Name and address of person who completed cause of death (Item 23a) (Type III) A Mit HAR M.D. 2337		Basto	MD 2/2	44
	Sta Registra	te ar	31. Date filed (Month Day, Year) 32. Registrar's Signature	She she			. ,

			1 _ State	laryland /		tment of H		nd Mental Hy	201)5	01423
			Registrar 1. Decedent's Name (First, Middle, Last)			mouto or t	Jeann	2. Date of De	Reg. No.		3. Time of Death
	Physici /Medio		MADELEINE AN		UTH	2 was	KI	Month	Day	Year 05	12.10 PM
	Examir	ner	4a. Fecility Name (If not institution, give street and number HARBOR HOSPITAL		R	4b. City Town, or		Death CRE	4c. County		
	Funeral Director		5. Social Security Number 6. Sex 7. A 1	ge (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir Min. (Month, Da Aug. 2	th 17, 1929	Cour	place (State or Foreign htry) Vland
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	wn or Loca	ation		inag. 2	., 1323		Od. Inside City Limits
	Mary -f sho	ţ	Maryland N/A	Ba11	timor	e.					1⊠Yes 2 □ No
	r 28e	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	th with	alD	314 Washburn Avenue			2122	25		U.S	•	
920	72 hours atter death with the Maryland natural; or items 23a or 28e-f show time for atternities at the netities of	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ 1 □ Yes 2 □ 1 □ Yes Give 2 □ If Yes, Give 2 □ Year or Dates	f No ₹		as Decedent of Hi res, specify Cuba	ispanic Origin n, Mexican, P Specify:	? (Specify Yes or No Puerto Rican, etc.)		e - Americ k, White w Whi	
9	72 ho	ted	15. Decedent's Education	168	a. Decede	nt's Usual Occupa	ation	Comments	16b. Kind of Bu	isiness/In	dustry
21215-0036	within ene. then	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	5+)	life. Do	nd of work done d NOT use retired I ger	iuring most oi ()	working	Bell At:	lanti	.c Phone Co
	e file Il Hyg othe vent,	BeC	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Sumam	Θ)	
Maryland		To E	Thomas Cuddy			<u></u>		Barbara Ja			
Ma	12 s h ar reu		19a. Informant's Name/Relationship (Type, Print) John A. Rutkowski / Son			Address (Street a Shburn A		r Rural Route Numbe	er, City or Town, ore, Mary		
ē	s 1 and 2 if Health item 27 i	18	20a. Method of Disposition	20b. Place of	of Disposi	ion (Name of	1	Date	20c. Location -		
altimore,	0 0 1-		1 🔀 urial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	*		tory`or other place s Cemete	.	/21/2005	Baltimo		
Balti	permit. Pag Department Importent: t any injury o		21. Signature of Funeral Service Licensee	- /	1 22.	Name and Addres	s of Facility	Gonce Fun	neral Se	rvice	e, P.A.
			23a. Rart1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do						Mar	yland 21225 Approximate
	Pnysician		Immediate Cause (Final	ine. OCA ~	A.	0 1	Ca			-	Interval Between Onset and Death
	/Medical		resulting in death)	s a consequence	000	W 1	1 - Jest	1 CU ON		-11	MO WEEKS
	Examiner		Sequentially list conditions b.								
1/	sit ad	iner	cause. Enter Underlying	a consequence	of):						
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8760,	cate be execufed physician and the burial-transit	dical E	d	,							
9		ledic	U						10000		
.O. Box	that the death certific led by the attending p detached for use as	Physician/Me		of pregnancy 2 Fetal death at time of death		ctopic pregnancy Other (specify)			23d. Date Mor	e of delive	ry Day Year
ls, P	og De	by	Part II. Other significant conditions contributing to death	out not resulting	1	erlying cause give	0				e cause of death?
Sor	w requir been si should	etec	Character Co.		- (2	CUSE				
Records,	The lav	Completed	Congrestive Heart		Lia	e			rmed? d	rior to cor eath?	npletion of cause of
Vital		Be C	25. Was case referred to medical	1000	Im		26. Place of	1 ☐ Yes Death (Check only or		☐ Yes	2 No
of V	dis di	ToE	examiner? 1 ☐ Yes 2 🕱 No Hospital: 1 🖼 npati	ent 2 ER/O	utpatient	3□ DOA Othe	E.	ng Home 5 Resid		r (Specify)
o u			27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Da		Time of Injury	28c. injury Work		28d. Describe h	ow injury occurre	od	
Division	Attending ar death. ector: After by the fune	icati	2 Accident investigation 3 Suicide 6 Could not be	iver Albama 6			′es 2 □ No	206 1 16 76	1		
Ο̈́	el or Attends after death	Certification;	determined 200. Flace of III	jury - At home, fa tc. <i>(Specify)</i>	aim, siree	г, гассогу, опісе		City or Tow	itreet and Numbe n, State)	r or Hura	i Houte Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier (Check only one) Certifying Physician: To the best 2 Medical Exeminer: On the basis of and manner standard man	of examination ar	e, death o	ccurred at the tim stigation, in my op	e, date and pl inion, death o	lace, and due to the occurred at the time, o	cause(s) and mar date and place, a	ner as st	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed	(Month, I	Day, Year)
			om com			RE	5 00	00	01/1	8/0	5
	17		30. Name and address of person who completed cause of AYODELE AYOOLA, t				TAL	CENTER	L.		
	Sta	te	31. Date filed (Month, Day, Year)	rar's Signature							
	Registr	ar	~ = LUUJ REPLIE	. H.	Some						

State of Maryland / Department of Health and Mental Hygiene $\stackrel{2}{0}05$ For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 3.55P M Franklin KIGGIN /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner North Arundel Hospital Glen Burnie Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y Feb. 29, Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Ĭ920 212 12 4058 Maryland Director 84 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene.
sent of Health and Mental Hygiene.
sin: If Hear 27 le marked other than 'natural', or Hems 23e or 28e-1 show my or other traumatic event, its Maulcal Examinar man be nothing as 1 ☐ Yes 2X No Maryland Anne Arundel Glen Burnie Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21061 436 Browning Court U.S. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter Supermarket 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Riggin Rosaine Terret ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Riggin / wife 436 Browning Court Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If ony injury of Glen Haven Mem. Park 1/15/2005 Glen Burnie, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 23af Part1. Enter the disease of somplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland 21225 Approximate Interval Between Onset and Death Immediate Cause (Final nou mori a **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Senere Vasculv The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, the attending physician Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month detached for in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 9 Unknown δ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 I Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification; To this s after death.
I Director: After this of in by the funeral d 27. Mannut of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 24 hours a filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D14 136 10+1 612 Crawis Towers 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 11en Bur me 31. Date filed (Month, Day, Year)
JAN 2 1 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2005

			1 - For State Registrar		aryland / Dep <i>Ce</i>		Health and N	lental Hyg	_	. 011.25
	Physic	ian	Decedent's Name (First, Middle NAM)			DUDO	DII	2. Date of Dea		3. Time of Death
	/Medi	cal	ALVAN	M		RUDOL		JÄN".	18 ^{pay} 200	
1	Exami	ner	4a. Facility Name (If not institution, FOREST HAVEN NU			BALTIN	or Location of Death		4c. County of D	
	Funeral		5. Social Security Number	6. Sex 7. Aq	e (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)
	Director		214-03-5492	1 X M 2□F	84 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 07/30/	1920	pa pa
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				40d Jasida Cital limita
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent; If Item 27 is marked other then "naturel", or Items 23a or 28a-f show may injury or other treumatic event, I've Medical Evanting must be notified at ance.	tor		altimore	baltimo					10d. Inside City Limits 1 □ Yes 2 ☑ No
	or 28s	Funeral Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What	Country?
	ath w	rai	2504 SUMMERSON			21209			U.S.A	•
	ltems	ine	11. Marital Status 1 □ Never Married 2 📉 Marri	12. Was Decedent I Ammed Forces? ad 1 N Yes 2 □ N	1.0.1 T.T.	Was Decedent of If Yes, specify Cub	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		merican Indian, /hite, etc.
21215-0036	urs aff	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	40 *** 11	1 ☐ Yes 2 No	Specify:		Specify:	WHITE
2-0	72 ho	Completed	15. Decedent (Specify only highes	s Education	16a. Dece	dent's Usual Occu	pation	ina I	16b. Kind of Busine	ss/Industry
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	filed w Hygier ther ti		12 17. Father's Name (First, Middle, L	act)	SA	LESMAN	10 Mathada Na-	- /Firmh 84i-Juli	INSURA	NCE
and	buld be f Mental H arked of	o Be	RICHARD	В	RUD	OLPH	JEAN	e (FIIST, Middle, i	Maiden Sumame)	HERMAN
Maryland	2 should and Men is marke sumatic	To	19a. Informant's Name/Relationsh				t and Number or Run	al Route Number	, City or Town, State	
	1 and 2 Health a tem 27 Is		HILDA RUDOLPH /	WIFE		4 SUMMERS			RE, MD 212	
Baltimore,	of He		20a. Method of Disposition 1 △ Burial 2 ☐ Cremation	3 □Removal from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other pla	300)	Date	20c. Location - City	or Town, State
tim	ment tent: jury c		'4 ☐ Donation 5 ☐ Other (Sc	ecity)	RADOMER VI				ROSEDALE,	
Baj	permit. Pag Department Importent: I any injury o		21. Sign Was Funeral Serviced	icen ee		2. Name and Addre			SON & BROS	
		-	23a. Part1. Enter the disease, or	omplication that caused	the death. Do not en					E, MD 21208 Approximate interval Between
8760,	/Medical Examiner bhysician and bhysician and the priral-travsit the priral-travsit	icai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause. Enter Undertying that initiated events resulting in death) Last	Due to (or as b	a consequence of): a consequence of):	POTIC	Ceresi	-	CULAT	Sinset and Death
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant condition	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3 time of death 5	Ectopic pregnanc Other (specify)		23e. Did tob	23d. Date of c Month	delivery Day Year
rds	quires an sign uld be	q pa						1 🗆 Ye	es 2 No 3	Probabty 4 Uknown
ecords,	e law requ has been je 2 shouk	Completed						24a. Was ar		autopsy findings available
$\mathbf{\alpha}$		Com						autops perforn 1 Yes 2	ned? death	
Vital	icien: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	Cri			26. Place of Death			
of	Phys this raf dii	ation: To	1 Yes 2 No 27. Manne of Death Natural 5 Pending 2 Accident investig	28a. Date of Injur (Month, Day	nt 2 ER/Outpatier y 28b. Time o Injury	f 28c. Inju			nce 6 Other (Sp w injury occurred	pecify)
Division	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could no determine	28e. Place of Injubuilding, etc	ury - At home, farm, str :. (Specify)	eet, factory, office		28f. Location (Str City or Town	reet and Number or i , State)	Rural Route Number,
	To the Hospitel of within 24 hours at To the Funerel D completely filled in	Medical	29a. Certifier Certifying (Check only one)	Physician: To the best of xaminer: On the basis of and manner sta	examination and/or in	n occurred at the ti vestigation, in my o	me, date and place, opinion, death occurr	and due to the ca ed at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
	To the Mithin Fo the	Me	29b. Signature and title of certifier	/		29c. Licens	se number	29	9d. Date signed (Mo	nth, Day, Year)
			Jasnem	Vallu	ani	Do	28595		1/18/8	
	16		30. Name and address of person w	No completed cause of de	eath (Item 23a) (Type,	Print	28595- HEIGH	+73 A	VE BAC	10MD 2/201
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 1	2005 32. Registra	r's Signature	hade				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 05 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day JANUARY **Physician** Marie Elanor Rattini 6:00FPM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Saint Joseph Medical TOWSOT Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 9/23/1928 5. Social Security Number **Funeral** 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 XF 76 218-22-3324 Director Maryland Usual Residence of Decedent 2 should be illed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "naturel", or Items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other treumetic event, the Medical Examinar must be notified at Baltimore Towson Director 1 Tyes 25 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31 Lambourne Road 21204 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☒ No 3 Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant Social Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frederick W. Abt Sr. Anna Hilda Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is m any injury or other treum once. Frederick W. Abt III/Nephew 6601 Marietta Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 1/18/04 ^ 4 □ Donation 5 □ Other (Specify) Gardens of Faith Baltimore, Maryland 21. Sign ture of Funeral Jervice Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** ISCHEMIC CARDIOMYOPATHY /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Dnknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy prior to con death? 1 Yes 1 ☐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physicien: hours after death. filled in by the Director: within 24 hours a To the Funerel I

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D30263

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7601 ERANCIS OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year)

State Registrar

Medical

29a. Certifier

(Check only one)

JAN 2 1 2005

32. Restrar's Signature

			State of Maryland / Dep		•				
			1 - State Registrar Ce	. No 2005 01427					
Г	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death			
	/Media	cal	Francis Joseph Ritzman	1 0 7	January	18, 2005 1:00 A M			
	Examir	ner	4a. Facility Name (If not institution, give street and number) Stella Maris	4b. City, Town, or Location of Death		4c. County of Death			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,		8. Date of Birth	Baltimore 9. Birthplace (State or Foreign Country)			
ı.	Director		/1/-0/-9444	Months Days Hours Min.	8. Date of Birth (Month, Day, Y 11/16/1	905 Virginia			
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits			
	Maryl	tor	MD Baltimore Upperc	0		1 ☐ Yes 21 No			
	h the	lrec	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Country?			
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dical Exam he must be indiffed at	Funeral Director	16232 Falls Road	21155		U.S.A.			
	er deg	nue	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.			
336	urs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 22 ☐ No If Yes, Give 3 ② ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes XX No Specify:		Specify: White			
9-0	72 hours aft natural', or itral Exami	ted	15. Decedent's Education 16a. Dece	dent's Usual Occupation	16	b. Kind of Business/Industry			
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22			8 17. Father's Name (First, Middle, Last)	Lineman	ineman 18. Mother's Name (First, Middle, Main				
and	0 0 0 0	To Be	Joseph Ritzman		ine Stri	,			
Maryland 21215-0036	S P E E	F		ng Address (Street and Number or Rura					
	s 1 and 2 s f Health ar item 27 Is other trau		Robert F. Ritzman/Son 1811	5 Summerlin Drive	Hagersto	wn, Maryland 21740			
Baltimore,	00		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State	matory or other place)		c. Location - City or Town, State			
ţ			`4 □Donation 5 □Other (Specify) Parkwo			altimore, Maryland			
Bal	permit. Departr Importa any inju				el Funeral Home Inc.				
		6415 Belair Road Baltimore, Marylan 23a. Partl. Enter the disease, or portifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. As only one cause on each line.							
N	Pnysician		Immediate Cause (Final	Interval Between Onset and Death					
1	/Medical		disease or condition resulting in death) a	,					
6	Examiner		Sequentially list conditions, b. Alkoridor.	i Codoverell	5 Asce	all			
	led sit	Examiner	Sequentially list conditions, let y leading the force a consequence of: Due to force a consequence of: Cause, Disease or injury that initiated events c.						
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9	death certificate be executed e attending physician and of for use as the burial-transit	edi	IE ESMALE.						
Вох	ath ce ttendii or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □		23d. Date of delivery				
0.	at the deg by the a tached fo	ysici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month Day Year			
Д.	de de		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?			
rds,	quires n sign	d by	Squarous Cell Cancer	1 🗆 Yes	1 Yes 2 No 3 Probably 4 Monknown				
Record	aw requires been so should	ompieted	2		24a. Wasan	24b. Were autopsy findings available prior to completion of cause of			
Ä	The lav	mo			autopsy performed 1 ☐ Yes 2 2	d? death?			
Vital	Physician: Th this certificate ral director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death		12.100 2.2110			
of	Phys this al dir	L L	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien			e 6 Other (Specify)			
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Division	Attending I ar death. ector: After by the funer	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str		at and Number or Rural Route Number,				
٥	s afte	Cert	4 ☐ Homicide determined building, etc. (Specify)	Sta te)					
	Hospit t hour uner aly fills	edical	29a. Certifier (Check only (Ch	h occurred at the time, date and place, a	and due to the caus	e(s) and manner as stated.			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medi	one) and manner stated. 29b. Signature and title of certifier	29c. License number					
)	Z W Z	-	200. Signature and title of Certifier	1057283	1	Date signed (Month, Day, Year)			
	12		30. Name and address of person who completed cause of death (Item 23a) (Type,			771703			
	9		CHRISTOPHER ISH, M.D. 2300 DULANEY		NIUM, MD	21093			
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	hard .					

1:00 A.M.

FRANCIS RITZMAN JANUARY 18, 2005

	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 0 5								
	Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last) COVO Aa. Fecility Name (If not institution, give street)	and number)	Smith 4b. City.	Fown, or Location of Death	January_	Day Year 17, 2005 4c. County of Death	3. Time of Death
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. le	ast birthday) If Under Months Yrs.	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Yea Sept. 3	9. Birthp Coun	lace (State or Foreign try)
	ne Maryland Ba-f show	ctor	10a. State 10b. County NA	10c. City	Town or Location	Himore		1	0d. Inside City Limits 1 1 Pres 2 □ No
9	72 hours after death with the Maryland natural', or Itema 23a or 28a-1 show dical Evanting must be Louithed at	Funeral Director	1 Never Married 2 Married 1	as Decedent Ever in U.S med Forces? Yes 2 146		ant of Hispanic Origin? (Sp fly Cuban, Mexican, Puerto		14. Race - Americ Black, White,	an Indian,
1215-0036	within 72 hours. iene. than "natural", the Mudical Eval	Completed by	15. Decedent's Education (Specify only highest grade com	Yes, Give ear or Dates: pleted) ollege (1-4or 5+)	N 1 1	Occupation k done during most of work e retired)	ing 16b.	Specify: Bl	
Maryland 21	should be filed vand Mental Hygie is marked other t aumatic event, in	To Be Co	17. Father's Name (First, Middle, Last)	Sn	nith	Blan	e (First, Middle, Maide	en Sumame) UNK	ith
Baltimore, Mar	Pages 1 and 2 nent of Health ant: If Item 27 ury or other tra		19a. Informant's Name/Relations (Type, P. 20a. Method of Disposition 1 Burial 2 Perenation 3 Remov 4 Donation 5 Other (Specify) 21. Signatura Fune Service Licen	SON /Sister	ace of Disposition (Nammetery, crematory or other Cyce)		HYTE BO	Cor Town, State, Zip Control	91939
Ba			23a. Park Enter the disease, or complication shock of beart failure. List only one cau	ise on each line.	Do not enter the mode	of dying, such as cardiac	or respiratory arrest,	JESSUP	PA18434 Approximate Interval Between Onset and Death
8760,	Physician /Medical Examiner prize pr	al Examiner	disease of condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence to	Artery	Disease		7	One hour en years
P.O. Box 687	ate the	Physician/Medical	in the past 12 months?	yes, outcome of pregnan Live birth 2 Fetal of Deep Pregnant at time of deep Unknown	death 3 Ectopic pre			23d. Date of deliver	ry Day Year
	Physician: The law requires this certificate has been sign at director, page 2 should be	by	Part II. Other significant conditions contribut	ng to death but not resul	ting in the underlying ca	use given in Part I.		use contribute to the	
Vital Records,		e Completed	25. Was case referred to medical			26. Place of Death	24a. Was an autopsy performed? 1 Yes 2	prior to com death?	esy findings available aptetion of cause of
Division of V		Certification; To B	1 Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	1 Inpatient 2 E	М	Other: 4 Nursing Hor c. Injury at Work? 1 Yes 2 No	me 5 Residence 28d. Describe how inj 28f. Location (Street a	ury occurred	
Div	To the Hospital or Attending within 24 hours efter death. To the Funeral Director: After completely filled in by the funer		4 Homicide 29a. Certifier 1 Certifying Physicien	building, etc. (Specify)	ledge, death occurred a	t the time, date and place :	City or Town, Sta	te)	ited
	To the Hos within 24 ha To the Fun completely	Medical		- M.D	29c.	License number	29d. D	ate signed (Month, E	Pay, Year)
i	ત્ર		30. Name and address of person who complet			0005337	3 Ja	nuary, 17,	2005
	Sta Registr		31. Date filed (Month, Day, Year) JAN 2 1 2	32. Registrary Signatu	re	Var KWAY	100 TING	IC PU/S	-(010

			1- State of Maryland / Department of Healt Certificate of Dea	Ith and Me	ental Hygie	ne2005	01429
	Physic /Medi Exami	cal	Irma Jerychardt		2. Date of Death Month	Day Year 4c. County of Death	3. Time of Death
	Funeral Director			Jnder 24 Hrs. ours Min.	8. Date of Birth (Month: Day, Ye	9. Birth Cou	place (State or Foreign intry) yland
	vith the Maryland or 28e-f show be notified at	Director	10a. State 10b. County 10c. City, Town or Location Waryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code		10g.	Citizen of What Cou	10d. Inside City Limits 1 Yes 2 No
036	be lied within 72 hours after death with the Maryland Hygiene. But Hygiene. So or 28e-1 show ot other than "natural", or items 23e or 28e-1 show event, the Modical Examinar must be notified at	by Funeral	3819 Chestnut Road 21220 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Yes, Give Yes or Dates:	nic Origin? (Spec exican, Puerto R	city Yes or No-	14. Race - Amer Black, White Specify: Whi	can Indian, , etc.
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arylan	should and Mer s marke	To Be	William Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu	ith Tyler	(First, Middle, Maid Route Number, Cit	ly or Τοινπ, State, Zi	o Code)
ď	0 0	1	Carry Schuchardt, Husband 20a. Method of Disposition 1	Baltimore Da January	ite 20c.	21220 Location - City or T Itimore, Mai	
Balt	permit. Pag Department Importent: I eny injury o		21. Signature of Funer I Service Licensee 22. Name and Address of Factories, P.A. 119-121-S. Strick 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock or heart failure. List only one cause on each line.	leone Ct De	altimora Ma		
Ķ	/Medical / Medical al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate the first of the principle Cause (Disease or injury that initiated events resulting in death) Last Last of Cause (Final disease) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	uje			Inferval Between Onset and Death	
o xog .	e attending phy.	Physiclan/Medical	J. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)			23d. Date of delive Month	ary Day Year
ords, F	been signed by the a should be detached to	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	Part I.	23e. Did tobacco	o use contribute to the	
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SIVISION OF VITA	death.	atlon: To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DoA Cther: 4 December 2 Accident Single Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 2 St. Time of Injury Mork? Mork? MY 1 Yes 2	Nursing Home	Check only one) 5 Residence d. Describe how in	6 ∏Other (Specif) jury occurred	()
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To the	within 24 hours a To the Funeral I completely filled		29b. Signature and title of certifier 29c. License number 29c. License number	death occurred	at the time, date a	and manner as st and place, and due to late signed (Month, I	the cause(s)
	Sta Registr	tě	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. Maser Fl., Bade 22 S. Green St. (31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	Balto	.mD. 2	2/201	

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/Medic Examin		4a. Facility Name (If not institution, give s		?	4b. City, Town,	or Location o	1000	- 1	c. County of Death	
LAdilliii		Good Samarstan	- Hospital		Bul	timore	2		NA	
Funeral		5. Social Security Number 6. Sex	744	s. last birthday,	If Under 1 Year Months Days		Min. (Month	f Birth , Day, Year	9. Birth Con	nplace (State or Foreign untry)
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and		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or L	ocation					10d. Inside City Limits
Manyi f sho led a	ō	Md. NA		Baltin	nore					Y☐Yes 2☐No
the 1	rec	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Cou	untry?
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Balt permit. Depart Import any inj		21. Signature of Funeral Service License	10	1	2. Name and Addr		Dal		•	21202
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		shock, or heart failure. List only or Immediate Cause (Final	ie cause on each line.	0		_		•		Interval Between Onset and Death
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the de cy the a	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	1004(11 5)	Other (specify)			_		
IS, P.O. I	h Ph	Part II. Other significant conditions con	itributing to death but not re	esulting in the u	inderlying cause g	iven in Part I.	23e. [Did tobacco	use contribute to	the cause of death?
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VISION Of VITAI Attending Physician: or death. actor: Atter this certified by the funeral director.		27. Manner of Doath 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of		ury at ork?	28d. Descr	ibe how inju	iry occurred	
endir eath. or: Af	atic	2 Accident investigation			M 1	∃Yes 2 □ N	No			
Division of or Attending Phy after death. Director: After this in by the funeral d	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st cify)	reet, factory, office	9		on (Street a Town, Stat	nd Number or Rui e)	al Route Number,
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Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Diractor: After this certificate he completely filled in by the funeral director, page	Medical		sicien: To the best of my kiner: On the basis of examinand manner stated.							
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F 3 F ŏ		> Objana	5 MD		RE	500	20	Jan	mere !	2005 81
		30. Name and address of person who co	impleted cause of death (It	em 23a) (Type,	Print)			2 4	1	~/
2		Do love As	baturov.	5601	Loch	aven	Blvd; B	culti	more, No	<u>'</u>
Sta	ite	31. Date filed (Month, Day, Year) JAN 2 1 2005	32. Registrar's Sig	nature	2)					
Registr	ar	JAN 2 1 2005	fill the si	A CONTRACTOR OF THE PARTY OF TH						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 005 1 - For State Registre 01431 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Howar 0840 /Medical 2005 4a. Facility Name (If not Institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Maryland Baltmore Medical Center lleve Miversity NA 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 7-9-48 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1 X M 2 □ F Months Days Hours Director 214-54-2510 56 Md. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28e-1 show any injury or other treumatic event, the Medical Exercitival Liber profile. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. NA Baltimore 14 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 USA 501 W. Franklin St. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 💢 No Specify 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Painter Breckingridge Co. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Edward Stewart Gladys Scott ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 H Phlox Circle, Owings Mills, Md. Karen Stewart Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Greenmount Cem. 1-24-05 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East Warren 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** months Sophageon Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or a a cons or ence of) ician and burial-trans Due to (or as a consequence of) physician Physician/Medicai the attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months? Day 4 Pregnant at time of death Year signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 1 Yes 2 No 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' P

The law requires that the death certificate be executed Vital Records, P.O. Box 68760,∑ certificate has director, of this filled in by the funeral After Division or Attending death. Director: 24 hours a To the Hospitel

Baltimore, Maryland 21215-0036

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1

within 2

State Registrar

Certification:

Medicai

30. Name a addr of person who completed cause of death (Item 23a) (Type, Print) LEE MD.

MID

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32. Paistrar's Signature

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Don Schiller 190				17. Father's Name (First, Middle, Last)			7710	18. Mother's Name	e (First, Middle,	Maiden Surr	name)		
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200. Method of Deposition 3 Particular 200. Location - City of Town State 200	ary	shot and A uma	_	19a. Informant's Name/Relationship (Type, Print) (SOA)	19b. Mailing	Address (Street a			r, City of Tov	vn, State, Zip	Code 2/152	
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12221 104 AMORE D 11MONUM, MM 21093		spita ours neral filled		29a. Certifier 1 Certifying Ph	vsician: To the best of my know	wledge, death	occurred at the tim	e, date and place.	and due to the ca	ause(s) and	manner as st	ated	
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12221 TULL AMORE KD TIMONIUM, MD 21093)	1		> Husan D	Melhum		30	42410		11181	05		
31. Date filed (Month, Pay, Year) 32. Roistrar's Signature.		6		30. Name and address of person who	completed cause of death (Item)			, _ ,	101	1	20		
31. Date filed (Month, Quy, Year) 32. Recistrar's Signature.				1222 WIL	AMORE KI	0	limos	VIUM	MIN	210	15		
Registrar JAN 2 1 2005 Stewn S. Species	7	Sta		31. Date filed (Month, Ray, Year) 1	32. Registrar's Signat	ure.	rade						

		•	1 - For State Registrar	State of Maryland	d / Depa	rtment of h	lealth and l	Mental Hygi	ene g. No. 200	5 01433
			Decedent's Name (First, Middle, Last)		_			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Arnesto Stabilit	0				Jan. 18,		4:50 a ^M
	Examin		4a. Facility Name (If not institution, give str			-	r Location of Deat	h	4c. County of Dea	
			Heritage Nursing Ho			Dunda]			Baltimor	
	Funeral Director		130 03 0712	7. Age (In yrs. la	Yrs.	If Under 1 Year Months Days	Hours Min.		912 9. Bir	thplace (State or Foreign puntry)
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary f sho	ţō	Md. Baltimore	e D	undalk	2				1 ☐ Yes 2 No
	286 7.286	Director	10e. Street and Number		-	10f. Zip Code		10	g. Citizen of What Co	ountry?
	in 72 hours after death with the Maryland "natural", or items 23s or 28s-f show soleal Examinar must be mailfed at	a D	8148 Grayhaven Rd.			21	222		USA	
	deal	Funeral	11. Marital Status	2. Was Decedent Ever in U.S Armed Forces?	3. 13. \	Was Decedent of H	lispanic Origin? (S	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
õ	or its	Fu	1 Never Married 2 Married	1 AYes 2 □ No If Yes, Give	i	I ☐ Yes 2 🕱 No			Specify: W	
5-0036	hours after tural', or ite	d by	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:						
7	within 72 I ene. than "nat	lete	15. Decedent's Educa (Specify only highest grade	completed)	16a. Deced (Give	lent's Usual Occup kind of work done OO NOT use retired	ation during most of wo d)	rking	6b. Kind of Business	rindustry
7	within than than	Completed	Elementary/Secondary (0-12) 8 yrs.	College (1-4or 5+)		ainter	-,		Steel	
Maryland 2121	be filed within stal Hygiene.		17. Father's Name (First, Middle, Last)	<u>I</u>			18. Mother's Nar	ne (First, Middle, M	faiden Sumame)	
<u>a</u>	id be ental ked ic ev	To Be	Biagio Stabilito	0			Antoi	nette Ian	uzzio	
ar Z	should and Men s marks umatic		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailir	ng Address (Street	and Number or Ri	ural Route Number,	City or Town, State,	Zip Code)
	tra tra		Patricia Rykacze	wski niece	814	18 Grayha	ven Rd.	Dundalk M	id. 21222	
Baltimore,	es 1 an of Heali fitem 2 r other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	20b. Pl	ace of Dispo emetery, cren	sition (Name of natory or other plac	ce) Ton		20c. Location - City or	Town, State
Ĕ	permit. Pages Department of Importent: If it any injury or o		`4 □Donation 5 □ Other (Specify)	Ho]	ly Sep	ulchre Ce	Jan.	2005	Montgomery	Co., Pa.
ä	sparti sparti sport ny inj		21. Signature of Fundal Sovice Licensee	7 6	22	Name and Addre	Funeral	Home Of D	undalk	
	205 2		A ME me	0/1	1 7	7110 Soll	ers Poin	t Rd. 212	22	
			23a. Part 1. Enter the disease, or complications, or heart failure. List only one	ations that caused the death cause on each line.	. Do not ent	er the mode of dyir	ng, such as cardia	c or respiratory arre	st,	Approximate Interval Between Onset and Death
E	Pnysician		Immediate Cause (Final di Lise or condition resulting in death)	ACUTE Due to (or as a consequ	M	YOLAF	2.DIAL	. INFA	RCIKON	
	/Medical Examiner			Due to (or as a consequ	ience of):	71-11				naces a seminary
		7.	Sequentially list conditions, b.	HYPERT Due to (or as a consequ	ience of):	NON				
	ted nsit	를	cause. Enter Underlying Cause (Disease or injury	HYPOTA	-	51015	M			
	be executed ician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of);	<u> </u>				
760,	ate be executed hysician and he burial-transit	cai	L d.	ANEMI	4					
89	n certificat anding phy use as the									
Вох	eath certifica attending ph for use as th	ician/Med	230. was decedent pregnant	c. If yes, outcome of pregna 1 Live birth 2 Fetal		Ectopic pregnance	v		23d. Date of de	
	ne death the atte	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐Unknown		Other (specify)	,		Month	Day Year
P. 0.	that the de ed by the detached	by Physi	9 Unknown					One Distant		a the same of death?
	Se us		Part II. Other significant conditions cont	ributing to death but not rest	liting in the u	nderlying cause giv	en in Parti.	1	acco use contribute t s 2 □ No 3 □ P	robably 4 Dinknown
ord	w require been si should	Completed				 				
Sec	e law has b	du						24a. Was ar autops perform	y prior to	utopsy findings available completion of cause of
E	icien: The certificate rector, pag							1 ☐ Yes 2	1 □ Ye	s 200 No
Vital Records,	ysicien: The is certificate hidirector, page	Be	25. Was case referred to medical examiner?	ospital:		Ott	ner /	ath (Check only on		-
ō	Phys r this ral di	7.	1 Yes 2 No	28a. Date of Injury	28b. Time o	f 28c. Inju	ry at	· · · · · · · · · · · · · · · · · · ·	nce 6 ⊡Other <i>(Spe</i> w injury occurred	эсігу)
o	ding th.	盲	1 V atural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	rk?]Yes 2∐No			
Division of	Atten r dea sctor by the	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho		eet, factory, office		28f. Location (Sti	reet and Number or R	ural Route Number,
2	al or	Certification;	4 Homicide	building, etc. (Specify	<i>(</i>)			City of Town	, 3(4(4)	
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Medical (icien: To the best of my kno er: On the basis of examinal and manner stated.						
	To th within Fo th	Me	29b. Signature and title of certifier			29c. Licens	se number	25	od. Date signed (Mon	th, Day, Year)
)	^		Salindos	K Tul	KO N	1D. DO	7188		1/18/0	5
	'}	+	30 Name and address of person who cor	mpleted cause of death (Item	23a) (Type,	Print)	DI	8	1	
_			Savinder 11	16011 2	Ma	Let 1	ace	Diente	th 47	2/222
	St Regist	ate	31. Date filed (Month, Par Year) 1 2	32. Registrar's Signa	tufe	A SOULU				
		17:1		97	-	AD:				

			For Stata	State of	Marylan			of Health and	Mental F		7111	15	011.31.
	•		1. Decedent's Name (First, Midd	oi Dealii	2. Date of	Reg. N	No.	-	3. Time of Death				
	Physici /Media		Ruth	A	•		Sco	tt	Janua		19 2	Year 005	12:43a.M
	Examir		4a. Facility Name (If not institution	on, give street and numb	er)		4b. City, Tov	vn, or Location of Deat			c. County		
		٠	Blue Point N					imore					
	Funeral Director		5. Social Security Number	6. Sex 7. 1 ☐ M 2√☐ F	Age (In yrs. 94			ear If Under 24 Hrs ays Hours Min.	(Month,	Day, Yea	ır)	9. Birthp Cour	lace (State or Foreign ntry)
			214-01-9589 Usual Residence of Decedent		94	t .			⊥06	04	10	M	D
	72 hours after death with the Maryland hatural', or Items 23a or 28e-f show diest Examiner must be notified at	Ĺ	10a. State 10b. Count	y	10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	Be-fs	Funeral Director	MD N	Α	Ва	ltimo	re						1 X Yes 2 No
	with the	Dire	10e. Street and Number				10f. Zip Co	de		10g. C	Citizen of W	hat Cour	itry?
	eath	eral	1727 Druid P	ark Lake				1217	San - 18 - 19 - 1 - 1	1		. A .	
(0	riter d	Fun	1 Never Married 2 Ma	Armed Force	s?	"	Yes, specify	of Hispanic Origin? (S Cuban, Mexican, Puer	to Rican, etc.)	No-		- Amend , White,	an Indian, etc.
8	ral, o	l by	XXWidowed 4 □ Divorce	If Yes Give	_	1	☐Yes 2X	No Specify:			Specify:	в1	ack
Maryland 21215-0036	72 h	Completed by		nt's Education est grade completed)		(Give	ent's Usual O kind of work d	one during most of wo	rkina	16b.	Kind of Bus	siness/Ind	dustry
121	e filed within at Hygiene. I other than vant, I've Mer	ldm	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. L	OO NOT use re	etired)	9		ша	ani	# a]
2	filed v Hygie ther t	Co	12th grade 17. Father's Name (First, Middle	Last) na		P	итеро	tomist 18. Mother's Nar	no /Eimt Mide	do Maide		spi	<u> </u>
au	ld be ental kad o	To Be	Marshall Car					Bertha			on Sumame	''	
ary	2 should be tand Mental tis markad or aumatic eva	-	19a. Informant's Name/Relation			19b. Mailin	g Address (St	reet and Number or Ru			or Town, S	State, Zip	Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. Itam 27 is marked other than "natural", or Items 23s or 28e-f show other traumatic evant, If a Medical Examiner must be notified at		Catherine V. 20a. Method of Disposition	Jessup-S	ister								
altimore,	es 1 and the fitam		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation	3 Permanual from Sta	20b. P	lace of Dispos	sition (Name o	f place)	Date	20c.	Location - C	City or To	wn, State
Ĕ	Pag ment ant: I ury o		'4 □ Donation 5 □ Other (Me	tro C	remat	ory Inc.	1/24/	05 E	Balti	mor	e,, Md
Ball	permit. Pages i Department of H Important: If its any injury or ot once.		21. Signature of Fundal Service	Licensee	7011 1	22 M	Name and A	H West	D 1				01015
			23a. Part1. Enter the disease, or	or complications that caus	sed the death	. Do not ente	r the mode of	abash Ave	or respiratory	timo	ore,	Md	21215 Approximate
	Pnysician		Immediate Cause (Final	t only one cause on each	iline.	0/0	2		, ,				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or	as a consequ	ience of):	100						101-7
	Examiner		Sequentially list conditions,		ene	Bal	AL	re Schero	1-			1	d
	<u>بن</u> و	iner	any, leaving to infinediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	lante ofj.			1				17
	ficate be executed physician and is the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequ	ones of).							
68760,	be e.	alE		500 10 (6)	as a consequ	161108 01).							
687	ficate p phys s the	edical		d.									
Вох	The law requires that the death certifi te has been signed by the attending oage 2 should be detached for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon	ne of pregnar						23d. Date	of deliver	v
	death	Physician/M	in the past 12 months? 1 □ Yes 2 ☑ No	1☐Live birth 4☐Pregnant	at time of de		Ectopic pregna Other (specify				Mont		Day Year
P. O.	that the de led by the a detached i	Phys	9 Unknown	9□ Unknown									
	res tha igned be det	by	Part II. Other significant conditi	ons contributing to death	but not resu	lting in the un	derlying cause	given in Part I.					a cause of death?
oro	w require been si should I	eted							1	Yes 2	No 3	Proba	ibly 4 Unknown
Jec	has b	ompleted							24a. Wa	opsy	pri	or to com	sy findings available pletion of cause of
Vital Records,		O.							1 ☐ Yes	formed?		ath?] Yes :	2□ No
	Attanding Physician: or death. actor: After this certification in the funeral director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:			-5-c-i	26. Place of Dea Other:					
Division of	g Phys er this eral di	-	27. Manner of Death	1 ☐ Inpa 28a. Date of Ir (Month, L	-	R/Outpatient 28b. Time of	28c. l	Other: Nursing H	ome 5 ☐ Re 28d. Describe	sidence e how init	6 Other	(Specify) i	
0	nding Fath. r: After e funera	ertification:	1 Accident 5 ☐ Pendir		Day Year)	Injury		Work? I □ Yes 2 □ No					
<u>S</u>	or Attano after death Diractor:	tific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 288. Place of	njury - At hor	ne, farm, stre	et, factory, offi	се	28f. Location	(Street a.	nd Number	or Rural	Route Number,
	spitel or A ours after naral Dira filled in by	O											
	To the Hospitel within 24 hours a To the Funeral C completely filled	edical	(Check only 2 Medical	ng Physician: To the bes Examinar: On the basis	st of my know of examinati	rledge, death on and/or inve	occurred at the	e time, date and place, ny opinion, death occur	and due to th	e cause(s	and mann	ner as sta	ted. the cause(s)
	o tha ithin 2 o tha omplei	Med	one) 29b. Signature and title of certifie	and manner	stated.	\rightarrow	29c Lic	ense number		20d D	to signed /	Month O	av Vaarl
	F M F 0	2)				7	21344		2.5U. DE	l, o	world, D	uy, 1 (ai)
1	1/1	-	30. Name and address of person	who completed cause of	death (Item	23a) (Type P	rint)	entre, date and prace, yo pointon, death occur ense number		-//	1/4	<i>Y</i>	
• /	2		MEIN	nAn .	27/7	Han	mond	Ferry le	A RI	Ten	MD	21	22)
	Stat		31. Date filed (Mont) PAT. Par	2005 32. Pgis	trar's Signati	Ire				-10	-		
	Registra	ar		2005	was s	O A	and of						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month н. Slease January 13 2005 8:50 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7101 Bay Front Drive, #519 Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
July 26,1916 Birthplace (State or Foreign Country) 1 X M 2 ☐ F Days Hours Yrs. 206-07-3612 88 Director New Jersey Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County ?7 is marked other than "neturel", or Items 23a or 28e-f show treumatic event. It a MeJical Ever it at insist be rigitied at 10d. Inside City Limits Director 1XXYes 2 □ No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7101 Bay Front Drive, #519 Completed by Funeral 21403 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, should be filed within 72 hours after and Mental Hygiene. marked other than "neturel", or Itel Black, White, etc. 1 Never Married 2XXXMarried 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lawyer Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde H. Slease Caroline Schutte and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Eleanor C. Slease (Wife) 7101 Bay Front Drive, #519, Annapolis MD 21403 Saftimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ō permit. Page Department of Importent: If any injury or once. * 4 □ Donation 5 □ Other (Specify) Metro Crematory 01/15/2005 Baltimore, MD Name and Address of Facility
 Hardesty Funeral Home, P.A.
 Ridgely Avenue, Annapolis, MD 21401 21. Signature of Funeral Service Licensee Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician disease or condition resulting in death) /Medical Due to (or as a co ence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): use as the burial-transit certificate be executed Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) as been signed by the a 9 Unknown Part - Other significant conditions contributing to death but no resulting in the underlying causa (liven in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No Completed 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performed? Yes 254No page certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 28d. Describe how injury occurred

68760 P.0. of Vital Records, Physicien: funeral director, this Certification: After To the Hospital or Attending

within 24 hours after death.

To the Funerel Director: At completely filled in by the fu hours after death.

20

State Registrar

Medical

27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 - Homicide

(Check only one) 29b. Signature and title

5 Pending 6 Could not be determined 28a. Date of Injury (Month, Day Year)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

138958

29d. Date signed (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

strar's Signature

Annapoles Road # 106 Odenton MD21113

P	
Division of Vital Records, P.O. Box 68760,	Baltimore, Maryla
ppitel or Attending Physician: The law requires that the death certificate be executed X Z Z ours after death.	
neral Director: After this certificate has been signed by the attending physician and	Department of nearth and Men

		Please Type or Print in Black Indelib State of Maryland / Department 1 - State Continue Cont				011.36
Physic /Medi	cal	1. Decedent's Name (First, Middle, Last) Walter Felix Szymczewski, Sr.		Rag. 2. Date of Death Month JAman y	Day Year	3. Time of Death /6: /5 A.M.
Funeral Director	ner	North Arundel Hospital Gl	der 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, Ye Sept. 3,	ANNE ARU 9. Birth 1915 Mar	
the Marylan 28a-f show	rector	10a. State 10b. County 10c. City, Town or Location 10b. Severn 10c. Street and Number 10c. City, Town or Location	Zip Code		Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygienes the filem 27 is marked other tran "netural", or items 23e or 28e-f show other traumetic event, it a Marstal Example of the incitied at	by Funeral Director	1461 Washington Avenue 11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No	21144 edent of Hispanic Origin? (Speciedity Cuban, Mexican, Puerto Ri		USA 14. Race - Amer Black, White	ican Indian.
illed within 72 ho Hygiene. ther than "neturi nt, It a Morcal	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT	work done during most of working use retired) cal Mechanic	7	Aircraf	
	To Be	Arthur Szymczewski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addre	18. Mother's Name (Se	bon	p Code)
permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tra		20a. Method of Disposition 1XXBurial 2 □ Cremation 3 □ Removal from State 1.4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Nomentary, crematory of Clen Haven Centre)		2005 G.	.Location - City or T len Burnie	
/Medical Examiner	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the most shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	Accident	Annapol:	is, MD 214	Approximate Interval Between Onset and Death
ne death certificate be the attending physicia hed for use as the bur	hysician/Medical Ex	Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Due to (or as a consequence of): d. 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic 4 Pregnant at time of death 5 Other (s	oregnancy specify)		23d. Date of delive	ery D <i>a</i> y Year
le law requires that the has been signed by ge 2 should be detac	_	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	1 ☐ Yes 24a. Was an autopsy	24b. Were auto	he cause of death? pably 4 Unknown psy findings available impletion of cause of
Physician: this certifica al director, p	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 2 Accident investigation 3 Suicide 4 Homicide 28. Date of Injury (Month, Day Year) 28. Date of Injury 28b. Time of Injury M 28e. Place of Injury - At home, farm, street, facto building, etc. (Specify)	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	5 Residence	1 ☐ Yes 6 ☐ Other (Specificity) occurred	
To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical		n, in my opinion, death occurred a	at the time, date a	and place, and due to Date signed (Month,	Day, Year)
3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HENCY FRANC'S MO North ARU	adel Haspatal	,66- B	12/2005 urnic, M	Ð
Stat Registra IMH 17 Rev 1/200	ar	JAN 2 1 2005 Seem & South				
		ORIGINAL				

			For State Registrar	State of I	Maryland /	Depa <i>Cei</i>	artment of H	ealth a Death	and Menta		ene2 () (15	014	37
	F - F		Decedent's Name (First, Middle, La	st)						e of Death			3. Time of	Death
	Physici		Norman Harry Sev	ere Jr.					JANU	ARY		Year	13:06	PM
	/Medio Examir		4a. Facility Name (If not institution, giv	e street and numbe			4b. City, Town, or	Location o	f Death		4c. County of	f Death	1	
			St. Agnes H.	ealthear	re		Ba	ltime	ore		N	/A		
	Funeral		Social Security Number 6. S		Age (In yrs. last b	irthday)	if Under 1 Year Months Days	if Under		of Birth			lace (State o	or Foreign
	Director		216-24-9153	M 2□F	74	Yrs.		1100.5	Jul.	12,	1930		yland	
	pu 🛾		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Toy	wn or Lo	cation					1	0d. Inside Ci	ity Limite
	sho	7		Α.	100. 01.9, 100	01 20						'	1X Yes	
	28a-f	Director	MD N/	A			Baltimore	3		10	g. Citizen of W	bal Caus		
	with a or							000		10	-		1	
	eath	erai	1311 Herkimer Str	12. Was Decede	nt Ever in IIS	13 \		L223	nin? (Specify Ve	s or No-			States an Indian,	3
	ter d	Funerai	1 ☐ Never Married 2 ☑ Married	Armed Force	s?		Vas Decedent of Hi. f Yes, specify Cubar	n, Mexican	, Puerto Rican,	etc.)		, White,	etc.	
36	urs at	by	3 ☐ Widowed 4 ☐ Divorced	if Yes, Give Year or Date			I□Yes 2₺No	Specify:			Specify:	Wh	ite	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, its Medical Examinate multiple at		15. Decedent's E		168	a. Deced	lent's Usual Occupa	ition		16	6b. Kind of Bus	iness/Inc	dustry	
215	within 7. iene. than "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4d	or 5+)	lite. I	kind of work done d DO NOT use retired,	uring mosi)	of working					
21	d with	mo;	7				Truck Dr	iver			Fr	iegh	t	
p	oe filed within all Hygiene. I other than 'vent, IIIe Ma	Be (17. Father's Name (First, Middle, Last					18. Mothe	r's Name (First,	Middle, Ma	aiden Sumame)		
<u> a</u>	should be ind Mental I	70	Norman Harry Seve	re Sr.				Mara	agaret 0	ray				
Maryland	2 sho and l s ma		19a. Informant's Name/Relationship (Type, Print)	19	b. Mailir	g Address (Street a	and Numbe	r or Rural Route	Number, (City or Town, S	itate, Zip	Code)	
≥ (Joan Severe Wif	e			Herkimer	Stree						
ore	of H if ite	110	20a. Method of Disposition Burial 2 Cremation 3	Removal from Sta	te cemete	ery, crer	sition (Name of natory or other place	1	Date		Oc. Location - C			
Ë	Paginent:	1	' 4 □ conation 5 □ Other (Specia		Bayva		rematory,				Baltim			
Baltimore,	permit. Pages 1 and Department of Healti Important: If item 27 any injury or other t	1	21. Sign , velo Hi eral Service	NA	DOIX	/	. Name and Addres					-		
	20 = 6 O		Con www	MICK	The	_	28 Sulphu	-				MD 2		
P			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each	sed the death. Do n line.	not ent	er the mode of dying	g, such as	cardiac or respir	atory arres	st,		Approximate Interval Bet Onset and I	ween
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Freur	noma								1 wee	
	/Medical Examiner		resulting in deality	Due to (or	as a consequence	of):								
P		er	Sequentially list conditions,	b. Dua to for	as a consequence	Ceffe.								
	pet usit	nine	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2001010		,,								
	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	Due to (or	as a consequence	of):						-	_	
8760,	siciar buri	dicai E		đ										
687	ficate g phy:	0		" u										
Вох	eath certifi attending for use as	M	iF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor							23d. Date	of delive	ry	
m	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant	i 2 ☐ Fetal deat tat time of death		Ectopic pregnancy Other (specify)				Mont	h	Day h	Year
0	by the a	Physician/M	9 🗆 Unknown	9□ Unknowr	1									
٣.	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	by P	Part II. Other significant conditions	ontributing to deat	h but not resulting	in the u	nderlying cause give	n in Part I.	23	e. Did toba	icco use contrib	oute to th		
rd	w require been sig should b	edi		rdiam	yopaltu	1				1 Tes	2 □ No 3	Prob	ably 4 2	Jnknown
Records,	s bee	plet	Aortic Steno	51'S					24	a. Was an	24b. W	ere autop	osy findings	available
R	: The law icate has	Completed								autopsy performe Yes 2	ed? de	ath?	npletion of c	3050 OI
Vital		a	25. Was case referred to medical					26. Place	of Death (Checi					
>	Q 5	To B	examiner? 1 Tes 2 No	Hospital:	atient 2 ER/O	utpatien	t 3 DOA Othe	er: 4 🗀 Nu	rsing Home 5[Residen	ice 6 Other	(Specify	<i>'</i>)	
J of	ding Ph h. After thi funeral	1.1	27. Manner of Death	28a. Date of I		Time of injury	28c. Injury Work	at	28d. De	scribe how	v injury occurre	d		
Ö	tendir death. tor: Af the fur	atic	2 Accident investigatio	n		,		/es 2 □ l	No					
Division	r Atte	Certification:	3 Suicide 6 Could not be determined	280. Flace of	Injury - At home, f etc. (Specify)	arm, str	eet, factory, office			ation (Stre	et and Number State)	or Ruma.	l Route Num	ber,
	ital o	Cer												
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	icai	(Check only 2 Medicel Exa	niner: On the basis	s of examination a	ge, death nd/or inv	occurred at the tim	e, date and	d place, and due	to the cau	ise(s) and man e and place, ar	ner as stand due to	ated. the cause(s	.)
	the the mplet	Medical	one) 29b. Signature and title of certifier	and manner	stated.		29c. License				d. Date signed			
	To To		Mulcarusus	Talle	(mepic	AL			2		_			
	/	1		•				861.			iomuar			
	5		30. Name and address of person who MUHAMMAD To		of death (Item 23a)	Type,	S. Caton 7	AVPANI	1. Bal	timor	re MA	21	229	
	0	at o	31. Date filed (Month) Pau Yaar)	32. R	strar's Signature	100	5.040W /	10000			0,	,0010	~~ /	
P	Sta Registi		31. Date filed (Month JAN Y2ar) 1	2005	strar's Signature		Sand "							

DHMH 17 Rev 1/2001

SEVER , NORMAN

Physici		Registrar 1. Decedent's Name (First, Middle, Li			rtificate of		2. Date of De			Time of Death
/Medic		NEIL S	SIMA	NONDS			Month	ey 17.	2005 12	2:30 A
Examin		4a. Facility Name (If not institution, gi	ve street and number) AVENUE		4b. City, Town, HALETA	or Location of De to RSE	ath	4c. County	of Death	Baltimo
uneral irector		212-23-6667		(ast birthday)	If Under 1 Yea Months Days			ly, Year)	9. Birthplace Country) Mary	(State or Foreig Land
f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Baltin		ity, Town or Lo						nside City Limit □Yes 2ӁN
3a or 28a	il Direct	10e. Street and Number 5030 Arbutus Ave	2.		10f. Zip Code 212			10g. Citizen of V		
Department of nearly and worked or rygene. Department of near 27 is marked or that then "natural", or itams 23e or 28e-f show any injury or other traumetic avent. The Medical Examinat must be notified at once.	by Funeral Director	11. Marital Status 1 ⅓ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu		(Specify Yes or No erto Rican, etc.)	14. Race Blace Specify	e - American Inck, White, etc.	
en "natur Medical	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5+)	(Give		e during most of a red)	working	16b. Kind of Bu		у
d othar th avant, the	Be	11 17. Father's Name (First, Middle, Las		N/A	(Studer		lame (First, Middle	, Maiden Sumam	N/A	
narka netic	P	Frank H. Simmon		-		1	onna Ste			
m 27 Is m		19a. Informant's Name/Relationship Frank Simmonds	, III / father	5030	Arbutus sition (Name of		Rural Route Numb Ialethory Date	e, MD.	21227	
tent: If ite		20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Spec	□Removal from State ify)	cometery, crer Loudon	natory or other pl Park Cen	netery (01-19-05	20c. Location - Baltim	ore, M	
any irr		21. Signature of Funeral Service Lice		A 1	328 Sulp	uneral E hur Spr	Home, Inc	Arbutus,	MD. 2	21227
/sician ledical		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused the der y one cause on each line. a. Due to (or as a conse	SARCOL		ring, such as card	liac or respiratory a	rrest,	Inte Ons	roximate rval Between set and Death
attending physician and for use as the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	quarca of):						
y the attending phy iched for use as the	by Physician/Medic	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	tal déath 3□	Ectopic pregnan	су		23d. Dat Mor	te of delivery nth Day	Year
been signed by the a should be detached f		Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause g	rven in Part I.	23e. Did 1	obacco use contr		use of death?
	Completed							psy ormed?	Were autopsy fi prior to complet death?	tion of cause of
has je 2		25. Was case referred to medical				26. Place of D	1 ☐ Yes Death (Check only of		I□Yes 2	140
ate has page 2	0		Hospital:	☐ ER/Outpatier	nt 3 DOA		Home 5 Resi	dence 6 Othe		
fter this certificate has neral director, page 2	To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	W					
n. After this certificate has funeral director, page 2	To Be	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M 1[⊒Yes 2□No	28f. Location (City or To	Street and Number wn, State)	er or Rural Rou	ite Number,
n. After this certificate has funeral director, page 2	Certification; To Be	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not determine	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At	28b. Time of Injury home, farm, strifty)	M 1 [Yes 2 No	City or To	wn, State)	nner as stated	
fter this certificate has neral director, page 2	To Be	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not 4 Homicide 29a. Certifier 1 Certifying F (Check only 2 Medical Exa	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At building, etc. (Spectaring)	28b. Time of Injury home, farm, strify) nowledge, death nation and/or in	M 1[reet, factory, office h occurred at the vestigation, in my 29c. Licer	Yes 2 No note time, date and play opinion, death or onse number	City or To	cause(s) and ma date and place, a 29d. Date signed	anner as stated. and due to the	cause(s)

		. For								ene Legible.	01439
		State Registrar			Cer	tificate c	of Death			. No.	01405
Physici	an	1. Decedent's Name (First, Middle, Last Tammy L. Schouste	•						Date of Death Month	Day Year	3. Time of Death
/Medic									anuary	15, 2005	8:00 A M
Examin	er	4a. Facility Name (If not institution, give 3242 Kingslev S		er)		4b. City, Town	n, or Location o			4c. County of Deat	
E de la constant		3242 Kingsley S 5. Social Security Number 6. S		Age (In yrs. las	t birthday)	If Under 1 Ye		imore	Date of Birth		N/A
Funeral Director			□M 2 🛣 F	39	Yrs.	Months Da		Min. (Date of Birth Month, Day, Y eb. 21,	(ear) Co	pplace (State or Foreign untry) Maryland
פַ		Usual Residence of Decedent					1	1 - 1	21,	1505	riaryranu
urylan show	_	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
Ba-f	Director	MD N/A				Balti					1X☐ Yes 2 ☐ No
with ti	ā	10e. Street and Number				10f. Zip Cod			10g	, Citizen of What Co	untry?
leath ns 23 must	Funeral	3242 Kingsley St	12. Was Decede	ent Ever in U.S.	13 \	Vas Decedent	2122		Yes or No.	United S	
ING K I K I S-UUSO be filed within 72 hours after death with the Maryland ital Hyglene. id other than "natural", or Items 23a or 28a-f show evant, the Medical Evaninar must be notified at	듄	1 Never Married 2 Married	Amed Force	es?		Was Decedent of f Yes, specify C			n, etc.)	Black, White	
hours at ural', or	ξ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	es:		l□Yes 21XII	No Specify:			Specify:	White
72 h	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Deced (Give	tent's Usual Oc kind of work do DO NOT use re	cupation ne during mos	t of working	16	b. Kind of Business/	ndustry
within the Man	m	Elementary/Secondary (0-12)	College (1-4	or 5+)			tired)			/.	
IIG Z IZ I 3-1 be filed within 72 h al Hygiene. I other then "natu want, the Medica		17. Father's Name (First, Middle, Last)			דת	sabled_	18. Mothe	er's Name (Fir	rst. Middle. Ma	N/A	
VIZITICI Suld be file Mental Hy arkad oth artic evant	To Be	Thomas Schouster							cia Kna		
Taryianne 2 should be f and Mental H is markad of raumatic eva	-	19a. Informant's Name/Relationship (19b. Mailir	g Address (Str	eet and Numbe			Dity or Town, State, Z	ip Code)
mod 2 strand 2 strand 27 is n		Patricia Beale	Mother		324	2 Kings	lev St.	. Balt	imore.	MD 21229	
es 1 ar of Hea of Hea		20a. Method of Disposition 1 Burial 2 Cremation 3	D	20b. Plac	e of Dispo	sition (Name of		Date		c. Location - City or	Town, State
Page ment ant: h		Donation 5 Other (Specify	/)	ate Dayv.		Inc.	1	1-17-20		altimore.	MD
DESILITIONE, INITY JEST PROPERTY PROPERTY PAGE 1 AND 2 SHOULD BE PROPERTY IN THE TEST PROPERTY IN THE TRANSPECT OF THE TEST PROPERTY PROPE		21. Signature of Funeral Service Licer	Constant	1					se Fune	ral Home,	Inc.
	U	Chy mine Ma		Q						nsdowne, l	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on eac	sed the death. h line.			· -				Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ACC	VILE) /	MM 41	VE D	EF10	SENC	y SYND	74Rg
Examiner			Due to for	as a conseque	nce of):					<i>'</i>	•
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or	as a conseque	nce of):						
ou, be executed ician and burial-transit	Examiner	that initiated events	C								
e exection are trial-th		resulting in death) Last	Due to (or	as a conseque	nce of):						
S S S	dicai	•	d								
HECOLOS, P.O. BOX 08/00, The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	/Med	IF FEMALE:	23c. If yes, outco	ma of programs	.,					Tr.	
BOX eath cer attendir for use	cian	23b. Was decedent pregnant in the past 12 months?	1 Live birt	h 2 Fetal di	eath 3⊑	Ectopic pregnal Other (specify				23d. Date of deli Month	very Day Year
the d	Physician/M	1 ☐ Yes 2 Mar No 9 ☐ Unknown	9□ Unknow			2 Ottler (Specify	/				
cords, r w requires that s been signed b should be deta	by Pł	Part II. Other significant conditions of	ontributing to dea	th but not resulti	ng in the ur	nderlying cause	given in Part I.		23e. Did tobac	cco use contribute to	the cause of death?
guire quire an sig									1 🗌 Yes	2MNo 3☐Pro	bably 4 Unknown
KECOLOS, he law requires t e has been signe tge 2 should be t	Completed								24a. Was an	24b. Were au	opsy findings available
	E O								autopsy performe 1 ☐ Yes 25	d? death?	ompletion of cause of 2 No
DIVISION OF VICAL REC all or Attending Physician: The law after death. Director: After this certificate has b	Be (25. Was case referred to medical examiner?				1000			neck only one		
On of VItal ding Phyalcian: h. After this certific funeral director,	၉	1 ☐ Yes 2 No	Hospital: 1 ☐ Inp		VOutpatien	1 3 DOA				ce 6 □Other (Spec	ufy)
Ing P	inol ::	27. Manner of Death 1 Natural 5 ☐ Pending		Day Year)	8b. Time of Injury	1	Nork?		Describe how	injury occurred	
JIVISION or Attending after death. Diractor: After	icat	2 Accident investigation 3 Suicide 6 Could not b		Injury - At hom	o larm etr		Yes 2 1		Location (Street	et and Number or Ru	m I Doute Number
DIVISION ALTRINATI	Certification:	4 Homicide determined	building	, etc. (Specify)	6, ram, str	eet, ractory, on	08		City or Town, S		at Hobig Namber,
DIVI To the Hospital or At within 24 hours after or To tha Funeral Dirac completely filled in by		29a. Certifier 1/2 Certifying Ph	ysicien: To the b	est of my knowle	edge, death	occurred at the	e time, date an	d place, and	due to the caus	se(s) and manner as	stated.
he Ho n 24 l ha Fu pletel)	Medical	(Check only 2 Medical Exer	niner: On the bas and manne	is of examination	n and/or inv	estigation, in m	ny opinion, dea	th occurred a	t the time, date	and place, and due	to the cause(s)
To the company of the	Σ	29b. Signature and title ol certifier				29c. Lic	ense number		29d	Date signed (Month	, Day, Year)
		MW and	de			0	290	7)		1-15-6	MD2122/
γ		30. Name and address of person who	completed cause	of death (Item 2	3а) (Туре,	Print)	-4		1.1	. 5	
		31. Date filed (Month, Day, Year)	USH~	TV C	x1/	U.FU	IAW	57 1	DICT	mont	MJ2122/
Sta Registr		A	2005 32. Heg	istrar's Signatur	- a						
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				0	RIGINA	L					

8 Am

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 07:00AM Elizabeth Oi 18 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hopkins Bayview Medical Center Baltimore N/A Johns If Under 1 Year | II Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 € XF 218-07-3004 Director July 31, 1919 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or items 23a or 28e-1 show any hjury or other traumatic event, the Maudical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Parkville Baltimore Maryland 1 ☐ Yes 2XXNo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8316 Nunley Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2/OXNo II Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Be Completed by Specify: white 3€XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In own home 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Owens Josephine Blessing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Saal 8316 Nunley Drive Parkville, Maryland 21236 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State Baltimore-Washington 1/24/05 Laurel, Maryland Crematory

22. Name and Address of Facility
Bur ee-Henss-Seitz Funeral Home, Inc.
3031 Falls Road Baltimore, Maryland 21211 * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses xca 23a. Part1. Enter the disk se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Dneumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 physician the attending IF FEMALE: should be detached for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2**X**No 3 Probably 4 □Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? Certification: 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Thomicide To the Hospitel within 24 hours at To the Funerel D 29a. Certifier Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ah L. Cummins M.D Jan. 18, 2005 RES- \mathcal{O}_{l} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cummins Deborah 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Registrar

ORIGINAL

		•	For State Registrar	State of N	Maryland	/ Depa		of He	alth an		ntal Hyg		05	0 4 4
	Plant		1. Decedent's Name (First, Middle, L							2.	Date of Dea	ath	Year	3. Time of Death
	Physicia /Medic		Crescencia B.	Sanchez							Month 01	18	2005	2:30p M
	Examin		4a. Facility Name (If not institution, g				4b. City, To			Death			ounty of Deatl	
E			7821 Epsilon		od MD Age (In yrs. last	t hirthdayl	Der If Under 1	WOOD] If Under 24	Hre o	Data of Dist		ontgom	
	Funeral Director		5. Social Security Number 6. N/A	1 ☑ M 2 ☑ F	64	Yrs.				Min.	Date of Birth	1 9 40	Ph	nplace (State or Foreign unity) Ilippines
		ŀ	Usual Residence of Decedent				1							11
	rylan thow		10a. State 10b. County		10c. City, T									10d. Inside City Limits
	8a-fs	Director	MD Montg	omery	Dei	rwood								1 ☐ Yes 2 ☑ No
	vith th	Dire	10e. Street and Number				10f. Zip C					_	n of What Co	-
	s 23c	erai	7821 Epsilon D	12. Was Decede	nt Ever in II C	12 1)855	anio Origin	2 (Specifi	. Vos or No		lippin Race - Ame	
	d within 72 hours after death with the Maryland siene. It fan 'natural', or Items 23s or 28s-f show then 'then 'natural' at saminer must be notified at the Madical Examiner must be notified at	by Funeral	11. Marital Status 12 Never Married 2 Married 3 Widowed 4 Divorced	Armed Force 1 Yes 23 If Yes, Give Year or Date	s? ∑No	13.	Was Deceder If Yes, specify 1 ☐ Yes 2	y Cuban,	Mexican, F	uerto Ric	an, etc.)		Black, White	
	72 ho	Completed	15. Decedent's (Specify only highest g	Education	1	16a. Dece	dent's Usual (Occupation	on	f working		16b. Kind	of Business/l	industry
	ithin 9	nple	Elementary/Secondary (0-12)	College (1-40	or 5+)		kind of work DO NOT use	retired)	ang most of	Working		0		
	D 00 =	Co	47. E-shada Nawa / Ciasa Middle / a	<u> </u>		Exa	miner	14	O Markeda	No (C	Y A # # # # # # # # # # # # # # # # #		vermen	t
	ntal H	Be	17. Father's Name (First, Middle, Last Ildefonso Sanc	_				- 1	Lucia	,	irst, Middle, 1 a	Maiden Su	<i>ma</i> me)	
	should I nd Men marke umetic	2	19a. Informant's Name/Relationship			10h Mailir	ng Address /					r City or To	own, State, Z	in Code)
	nd 2 sho		Lucila Cruz	(1)0,11111			-					-	rg Md.	
	iges 1 and 2 should be file to I Health and Mental Hyg If Item 27 is marked othe or other traumetic event,	1	20a. Method of Disposition			e of Dispo	sition (Name	of	1	Date			tion - City or	
	permit. Pages Department of H Important: If Ite any Injury or of angles.		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		te Che	esape	ake Cr	emat	ory C)1-19	-2005	Be1t	tsville	2
•	permit. Depart Import any Inj pnce.		21. Signature of Fundral Service Lic	ens you	2000	122	Rapp	Fune	eral δ	cre	matior	Serv	vices	
			28a, Part I. Enter the disease, or co	molications that caus	sed the death.	Do not ent	933 G	ist of dving	Ave S	Silve	r_Spri	ing MI	2091	Approximate
ä			23a. Part f. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final						30011 03 00	i diac or re	Spiratory an	.031,		Interval Between Onset and Death
	mysician /Medical		disease or condition resulting in death)	_ a	depatic		рторат	ту		-				1 year
	Examiner			(Cirrhosi									5 years
	1.3	Je.	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	b. Due to (or	as a consequen	nce of):								,
	cuted	Examiner	that initiated events	С.										
	ate be executed nysician and he burial-transit	EX	resulting in death) Last	Due to (or	as a consequen	nce of):								
	ficate physical fire the transfer of the transfer of the transfer of the transfer of trans	edical		d.						_			ĺ	
	eath certificat attending phy for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor								23d	1. Date of deli	very
	death	icla	in the past 12 months?	4☐Pregnant	n 2 □ Fetal de t at time of deat		Ectopic preg Other (spec						Month	Day Year
	that the de led by the a detached f	hys	9 Unknown	9□ Unknowr			_	_		-				
	res the igned be de	þ	Part II. Other significant conditions	contributing to deat	h but not resultir	ng in the u	nderlying cau	ise given	in Part I.					the cause of death?
	w requir been si should						-			-	1 ∐ Y	es 2□N	vo 3∐Pro	obably 4 Hunknown
	K	Completed								_	24a. Was autop	sy	prior to c	topsy findings available ompletion of cause of
											1 🗆 Yes	med? 2E No	death?	2□ No
	Physician: T this certificat al director, pa	Be	25. Was case referred to medical examiner?	Hospital:							heck only o			
	Phys rthis ral di	1: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of I	- 1	VOutpatier Bb. Time o		. Injury a			5 X Resid		Other (Spec	ify)
	Attending F r death. ector: After by the funera	tion	1 Natural 5 Pending 2 Accident investigat	(Month,	Day Year)	Injury	М	Work?	s 2∏No			,,		
	ist or Attendii s after death. al Director: A sd in by the fu	Certification:	3 Suicide 6 Could not determine	be 28e. Place of	Injury - At home etc. (Specify)	e, farm, str	reet, factory, o	office		28f.	Location (S City or Tow		lumber or Ru	ral Route Number,
	Hospil 4 hour Funera ely filla	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the be aminer: On the basis and manner	s of examination	edge, deat n and/or in	h occurred at vestigation, in	the time, n my opin	, date and p	place, and occurred a	due to the o	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	On			29c. l	License n	number		- 4	29d. Date s	igned (Month	, Day, Year)
			> prev	Alle	rell	Dru	0	D382	.62			01-1	8-2005	5
	16		30. Name and address of person wh	o completed cause of	of death (Item 23	За) (Туре,	Print)	Coit	homob		MD 200	77		
	1		Anurita Mendh:	ratta 50	L IN Frec	reric	k Ave	-ait	nersb	ourg 1	ти 208) / / 		
	Sta Registr	ite ar	JAN 2	2005	ars signatur	-								
ЭН	MH 17 Rev 1/2	001		2001	leter.	H.	Sports	1						
*1					OF	RIGINA	AL.							

			_ For	1 10030								ental Hy		egible.	•
			State Registrar				Ce	rtificate	e of L	Death			Reg. No.	005	01442
	Physicia	an	1. Decedent's Name		•	_						2. Date of De. Month	ath Day	Year	3. Time of Death
	/Medic		Ruth	Evel			oxel1					Januar	_	200	
	Examin	er	4a. Facility Name (If I		e street and nur	nber)			_	Location o	of Death			ounty of De	
	F		The Anna 5. Social Security Nu		ex	7. Age (In yrs.	last birthday)	If Under	apol	If Under	24 Hrs.	8. Date of Birt			rundel
	Funeral Director		182-07-6	4	□M 21/2 F	89	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da Jan. 2	y, Year) 3, 19		irthplace (State or Foreign Country) ew York
	ט		Usual Residence of [Decedent									J, 17	15, 11	
	show	_		10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	he M	by Funeral Director	MD	Anne Ar	undel		Annap		0.1				10 000		1 ☐ Yes 2 No
	a or a	Ö	10e. Street and Num			001		10f. Zip					10g. Citize	n of What (Jountry?
	eath	eral	931 Edge	wood Roa		201 dent Ever in U	S. 13	Was Deced		.403	nin? (Spe	ecity Yes or No		SA Bace - An	nerican Indian,
S	r iten	F	1 Never Marrie	d 2 Married	Armed Fo 1 ☐ Yes If Yes, Giv	rces?	ĺ					ecity Yes or No Rican, etc.)		Black, Wh	ite, etc.
93	rel', o	by	3X Widowed 4	Divorced	If Yes, Giv Year or Da	e ²¹ ites:		1 ☐ Yes 2	No.	Specify:			Sį	oecify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f show the Madical Examinar must be notified at	Completed	(Specif	15. Decedent's Ed by only highest gra	fucation de completed)		(Give	dent's Usua kind of wor	k done o	turina mosi	t of workii	ng	16b. Kind	of Busines	s/Industry
121	vithin han *	mpi	Elementary/Secon		College (1	-4or 5+)	life.	DO NOT us	e retired)			-		
22	lled v Hygie ther t nt, th		17. Father's Name (F	First Middle Last	4		Supe	rviso	r	18 Mothe	ar's Name	(First, Middle,		ial W	ork
and	ad of) Be	Isaac S.										Wallett St	nnanio)	
Maryland	should bd Me mark mati	7	19a. Informant's Nar		Type, Print)		19b. Maili	ng Address	(Street a			linner I Route Numbe	er, City or T	own, State	Zip Code)
	nd 2 :		William A			in-law)						napoli			
re,	of Heal		20a. Method of Dispo	osition		20b. F	Place of Dispo					ate			r Town, State
E	Page nent c int: If iry or		1.A.PBurial 2 ∟ . 4 □ Donation	Cremation 3 ☐ 5 ☐ Other (Specif		State	keview			٠,	01/15	5/2005	Cinna	minso	n, NJ
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or Items 23a or 28e-f show eny injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature of Fun	eral Service Liger	9 e		2	Name an	d Addres	s of Facilit	by aral	Home P	۸		
<u> </u>	89 6 9		77	9.0	m-		1 1/4	12 R	idge	1y Av	zenue	Anna	polis	MD 2	21401
ı			23a. Part1. Enter the shock, or heart	e disease, or com failure. List only	dicutions that cone cause on e	aused the deat ach line.	h. Do not en	er the mode	e of dying	g, such as	cardiac o	r respiratory ar	rrest,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (F	inal	a	emli	ta	7							Onset and Death
	/Medical Examiner		resulting in death)	(Due to (or as a consec	quence of):								Name of the second
		<u></u>	Sequentially list con- if any, leading to im-	ditions,	b. Due to (or as a consec	mence off.								
7	uted t insit	m	Cause (Disease or in	lying njury			,5555 5.,.								
Ć.	be executed lician and burial-transit	Examiner	that initiated events resulting in death) La	ast	C. Due to (or as a consec	juence of):								
760,	ate be executed hysician and the burial-transit	ical		•	d										
89	tific g p	Med	IF FEMALE:												
Вох	death certifica e attending ph ed for use as th	Physician/Med	23b. Was decedent in the past 12.0		23c. If yes, out 1□Live b	come of pregnation	Il death 3	∃Ectopic pr					230	d. Date of de Month	elivery Day Year
O.		sici	1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	4□Pregn 9□Unkno	ant at time of c	leath 5	Other (sp.	ecify)					MOUTH	Day 16a
P.O.	The law requires that the death cer te has been signed by the attendin age 2 should be detached for use	Ph	Part II. Other signific	cant conditions	ontributing to de	eath but not res	sulting in the u	nderlying ca	ause give	en in Part I		23e. Did to	obacco use	contribute	to the cause of death?
Records,	uires signe Id be	d by	F	aller	e ti	16011	l	, , ,					Yes 2□1		Probably 4 Whiknown
200	w req beer shou	lete										24a. Was	an 2	24b. Were a	autopsy findings available
Re	The law ate has page 2	ompleted										autop perfo	rmed?	prior to death?	completion of cause of
Vital		e C	25. Was case referre	ed to medical						26. Place	of Death	1 Yes	2 No	1 🗆 Ye	s 2 No
\ \	× × ×	To B	examiner?	40	Hospital:	npatient 2	ER/Outpatier	nt 3□ DO	A Othe	9r: 4 □ Nu	ırsing Hor	ne 5 ☐ Resid	dence 6	Other (Sp	ecity) ASS. Turus
n of	ng Pl		27. Manner of Death	5 Pending	28a. Date ((Mont	of Injury h, Day Year)	28b. Time o Injury	f 2	8c. Injury Work	at c?	2	28d. Describe h	now injury o	ccurred	
sio	Attending ir death. ector: After by the fune	cati	2 ☐ Accident 3 ☐ Suicide	investigation		44.1		М	_	Yes 2 🗍			2.		
Division	l or At after of Direct	ertification;	4 Homicide	determined	28e. Place	of Injury - At h ng, etc. (Speci	ome, farm, sti	eet, factory	, office		1	City or Tov		Number or F	Rural Route Number,
	spitel	O	29a. Certifier	Certifying Ph	vsician: To the	best of my kno	owledge, deat	h occurred :	at the tim	ne date an	nd place, a	and due to the	cause(s) an	nd manner a	as stated
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only one)	Medical Exam	niner: On the ba	isis of examina	ation and/or in	vestigation,	in my or	oinion, dea	th occurre	ed at the time,	date and pl	ace, and du	ue to the cause(s)
	To th withir To th comp	Me	29b. Signature and t	itle of certifier				29c	License	number			29d. Date s	signed (Mor	nth, Dey, Year)
	~		M						D	570	02	8	/	-17	-05
	10		30. Name and addre	ss of person who	completed caus	e of death (Iter	m 23a) (Type,	Print)	-1		1. 1	71 1		1	
			HUITYI	4 CHO	YRAY	MD. 6	OOKU	agel	MA	W.S	tc. L.	5/ AMI	rayou	01/5/	MD. 21401
	Sta Registr		31. Date filed (Month	JAN 2 1	2005 D	egie Signa	ature	Ter.	34				1	/	
	- 11091511				2000	a die	B	Great	20						

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ORIGINAL

			1 - State of State of State of State of State	Marylan		artment of H tificate of L			giene 005	01443
	Physici /Medic		Decedent's Name (First, Middle, Last) ETHEL LILLIAN THOMAS					2. Date of De	eath RY 18, 2005	3. Time of Death 10:20 AMu
	Examin		4a. Facility Name (If not institution, give street and numb WESTMINSTER NURSING/REHA		ER		Location of Death	1	4c. County of Dea	
	Funeral Director			Age (In yrs. I		If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da JULY	rth 9. Bir	thplace (State or Foreign ountry) ARYLAND
	ס		Usual Residence of Decedent 10a, State 10b, County	10c City	, Town or Lo	cation			7 1.20	10d. Inside City Limits
	Maryli I-f sho	tor	MARYLAND CARROLL	120,00,	MANCH					1 Yes 2 No
	or 288	Olrec	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	
	eath w	Funeral Director	4926 ROLLER ROAD 11. Marital Status 12. Was Decede	ent Ever in III	C 12.1	211(nosit. Van aa Na	UNITED ST	
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If Item 27 is marked other then "neturel", or Items 23a or 28a-f show or other treumatic event, the Medical Examiner must be notified at	þ	11. Marital Status XX Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceded Amed Force 1 Yes, Give 14 Yes, Give 15 Year or Date	s? XINo	1	Was Decedent of Hi f Yes, specify Cuba I □ Yes 2X No	Specify:	o Rican, etc.)	Black, Whi	
21215-0036	72 ho "netur	Completed	15. Decedent's Education (Specify only highest grade completed)		(Give	lent's Usual Occupa	during most of wor	king	16b. Kind of Business	/Industry
2121	within in within	omp	Elementary/Secondary (0-12) College (1-4	or 5+)		DO NOT use retired HOUSEKEEE	•		DOMESTIC	
	be filed tal Hygie d other event, II	Be	17. Father's Name (First, Middle, Last) LEWIS GARFIELD THOMAS						, Maiden Sumame)	
Maryland	shoutd be nd Mentat marked o	은	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	a Address /Street	REBECC		er, City or Town, State,	Zin Cade)
	and 2 sealth ar n 27 is		CHESTER B. THOMAS, SR/SON			ROLLER F		NCHESTE	-	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 eny injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from St.	ite c	emetery, cren	sition (Name of natory or other place	' I	Date	20c. Location - City or	
atir	nit. Pa artmer ortent injury e.		' 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service, Licensee	CAR		REMATION . Name and Addres	1	9/2005	HAMPSTEAD,	MARYLAND
ă	Depar Impo	0	Muster Duly		$\geq \frac{MY}{9}$	ERS-DURBO	RAW FUNE STREET	RAL HOM WESTMI	E. P.A. NSTER. MD	21157
ı		1	23a. Part . Enter the disease, or complications that cau shook, or heart failure. List only one cause on each immediate Cause (Final	sed the death h line.	n. Do not ente	er the mode of dying	g, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	as a consequ	ence of):	9				
ı	Examiner	L	Sequentially list conditions, bb.	1561	acio	1				
	uted g ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	as a consequ	ience of). ≟∠ l^∧ Li					
oʻ	icate be executed physicien and s the burial-transil		that initiated events resulting in death) Last C. Due to (or	a a consequ	uence of):	Ω	_	· ·		
68760,	ficate be executed physicien and s the burial-transit	edical	d. <u>En</u>	d d	tage	Ken	il d	us		
O. Box	death certii e attending id for use a	Physiclan/Me		n 2 ☐ Fetal t at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
rds, P.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contributing to deal	h but not resu	ulting in the ur	nderlying cause give	en in Part I.		tobacco use contribute to	o the cause of death?
Vital Records,	The ste h sage	Completed						24a. Was auto perfo	psy prior to death?	utopsy findings available completion of cause of
Vita	Physiclen: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?			Otho	26. Place of Dea	th (Check only o	one)	
of	Attending Physiclen: It death. ector: After this certific by the funeral director,	n: To	27. Manner of Death 28a. Date of	njury	ER/Outpatien 28b. Time of		4 LEDWISING H	ome 5 Resi 28d. Describe	dence 6 Other (Spe	cify)
sion	death. ctor: Afte	catlo	2 Accident investigation	Day Year)	Injury		(? Yes 2 □ No			
Division	r it o	Certification:	4 Homicide dolonimed building	etc. (Specify	′)	eet, factory, office		City or To		
	To the Hospitel or Attenwithin 24 hours after deati To the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1	s of examinat	wledge, death ion and/or inv	estigation, in my or	pinion, death occur	, and due to the rred at the time,	date and place, and due	to the cause(s)
	To COO	=	29b. Signature and two of certifier	iV	10	29c. License		210	29d. Date signed (Mont	
	8		30. Name and address of person who completed cause		00	Print)		-18	estminity 1	200
ζ.	Sta Registi		31. Date filed (Month, Day, Year) 32. Reg	in ars Signal	1	Malca	ilm du	re No	est minites !	ND 21159
	·······································		JAN 2 1 2005	Mary.	15	CHAZ)				

			riease i	State of Maryland				-	_	
			1 - For State Registrar	olato of Marylana		ficate of E			g. No.	0 1444
	Physici	an.	Decedent's Name (First, Middle, Last)	_	_			2. Date of Death Month		3. Time of Death
	/Media		Blanche		lay	101		January	17 2005	9:00 P. M
	Examir	er	4a. Facility Name (If not institution, give : Genesis Eldercal		1	16. City, Town, <i>o</i> r 1 Baltir			4c. County of De	ath Arundel
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. B	rthplace (State or Foreign
	Director		22, 11 2,0,	M 21X1F 90	Yrs.	Months Days	Hours Min.	(Month, Day, Oct. 14	77	rginia
	/iand iow		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Loca	tion				10d. Inside City Limits
	e Man	ctor	Maryland Anne Ar	undel Pas	sadena					1 ☐ Yes 2X No
	with th	by Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	leath in 234	eral	8430 Garden Road	12. Was Decedent Ever in U.S.	13 W:	2112		posity Vac or No	U.S.	odean Indian
ဖွ	after o	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 RHNo		s Decedent of His es, specify Cuban		Rican, etc.)	Black, Wh	ite, etc.
21215-0036	be filed within 72 hours after death with the Maryland ttal Hygiene. Id other than "natural", or Itams 23a or 28a-1 show other than "natural", or Itams 20a or 28a-1 show event. The Modical Exam are must be mortified at	d by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		Yes 21∕2 No	Specify:		Specify: W	
-51-	n "nat	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	16a. Decedei (Give kii life. DC	nt's Usual Occupat nd of work done du NOT use retired)	tion uring most of work	ting 1	6b. Kind of Busines	s/Industry
212	should be filed withir and Mental Hygiene. marked other than matic evant, IDE M.	Com	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		maker			Own H	ome
and	be filed Ital Hygi Ital other	Be	17. Father's Name (First, Middle, Last)	wloigh Class				e (First, Middle, M		
Maryland	2 should be and Mental is markad o aumatic eve	L C	19a. Informant's Name/Relationship (Ty.	rleigh Glass	10h Mailing	Address (Street as			e Richard City or Town, State,	
	S g is a		Richard Ragland			t. Paul			e, Maryla	
Baltimore,	ges 1 and it of Health If itam 27 or other tr		20a. Method of Disposition 1 □ Burial 2 XCremation 3 □ R	0000	oe of Disposit	on (Name of tory or other place	, [Date 2	Oc. Location - City of	r Town, State
ţ	Pa nen ant: ury		' 4 ☐ Donation 5 ☐ Other (Specify)	Bayv		ematory		/2005 E	altimore,	Maryland
Bal	permit. Departm Importal any inju		21. Signature of Funeral Service License) -	//	lame and Address)1 Ritchi	-	once Fune	ral Servi	ce, P.A. ryland 21225
			23a. Part1. Enter the disease, or comblishock, or heart failure. List only	idations that caused the death.				-		Approximate
	Pnysician		Immediate Cause (Final disease or condition	Munca	a iba		forct			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a 🛂 🔾 nsequer	nce of);		der in Or			
		ler	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequer	nce of):					
1.1.	cuted nd ransit	Examiner	mat minaten events)						
,092	te be executed ysician and te burial-transit		resulting in death) Last	Due to (or as a consequer	nce of):					
687	e %	edical		1						
Вох	eath certificat attending phy I for use as th	M/W	230. Was decedent pregnant	3c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal de		ctopic pregnancy			23d. Date of de	livery
O. B	at the deat by the att stached for	Physician/Med	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4 Pregnant at time of deat		ther (specify)			Month	Day Year
Q	that the		Part II. Other significant conditions con	ntributing to death but not resulting	ng in the unde	arlying cause giver	in Part I	23e Did tob	acco use contribute	o the cause of death?
Records,	The law requires that the death certifica tie has been signed by the attending ph page 2 should be detached for use as t	ed by				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 ☐ Yes		robably 4 Unknown
900	e law re has bee je 2 sho	Completed						24a. Was an	24b. Were a	utopsy findings available
E B		Сош						autopsy perform	ed? death?	completion of cause of s 2 No
Vital	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner?	lospital:		Other		h Check only one		
of		n; To	27. Manner of eath	28a. Date of Injury 28	VOutpatient Bb. Time of	28c. Injury a	at Nursing Ho	me 5 Resider 28d. Describe hov	ce 6 Other (Speringer)	ecify)
ion	Attending Fir death. actor: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work?	es 2 □ No		, ,	
Division	tal or Attendii s after death. al Diractor: A ad in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stree	, factory, office		28f. Location (Stre City or Town,	et and Number or F State)	ural Route Number,
	To the Hospital or a within 24 hours after To the Funeral Direct completely filled in b		29a. Certifier Physics 29a. Certifying Physics	sician: To the best of my knowle	edge death o	courred at the time	date and place	and due to the ear	ISO(a) and mennos	o stated
	he Ho in 24 h ha Fur pletely	Medical	(Check only 2 Medical Examination)	ner: On the basis of examination and manner stated.	and/or inves	itigation, in my opi	nion, death occur	red at the time, dat	e and place, and du	e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mon	th, Day, Year)
,			· yu	WD		D	53463	2	1/19/05	_
	10		30. Name and address of person who co	100 TRUC		nt) DAKWOO	2 0-	ad Gla	en Bornie	21061
	Sta		31. Date filed (Month, Day, Year) JAN 2 1 200	32 Registrar's Signature	θ	415-000	100	00 01	WY WIE	TIME
	Registr	ar	241 5 T 500	3 person B.	Goo	W				

		State of Maryland / Department of Health and N State Certificate of Death	Mental Hygier	01770
Physici /Medio	al	Decedent's Name (First, Middle, Last) CLARA ANNA TROUTNER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		Day Year 3. Time of Death 7. 26 fm
Funeral Director	ier	5. Social Security Number 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 40. City, Town, of Eccation of Beath 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 41. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 42. City, Town, of Eccation of Beath 5. Social Security Number	e	Boltmore 9. Birthplace (State or Foreign Country)
9		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	DEI 1. 17,	1913 MD.
the Mary 28e-f sh	Director	MD. BALTIMORE ESSEX 10e. Street and Number 10f. Zip Code	100	1 ☐ Yes 2 📉 No Citizen of What Country?
5-0036 2 hours after death with the Maryland turns, or items 23e or 28e-f show real Examiner must be notified at	Funeral	1000 FRANKLIN AVE., APT. 902 11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 27. Wideword 1 No Specify: 1 Yes, Give No Specify:		U.S.A. 14. Race - American Indian, Black, White, etc.
15-0036 72 hours after "netural", or Ite	eted by	3 Midowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work	tkina 16b	Specify: WHTTE . Kind of Business/Industry
2121 2121 8d within /giene.	Completed	Elementary/Secondary (0·12) College (1-4or 5+) Iife. DO NOT use retired) SALES CLERK		RETAIL
iore, Maryland 21215 ges 1 and 2 should be filed within 7, at of Health and Mental Hygiene. If item 27 is marked other than "n or other traumatic event, the Maryl	To Be		ne (First, Middle, Maid LA SANDERS	(en Sumame)
and 2 sho lealth and m 27 Is m		19a. Informant's Name/Relationship (Type, Print) RAYMOND SMYTH/SON 19b. Mailing Address (Street and Number or Ru. 2130 REDTHORN ROAD, B		
Baltimore, I permit. Pages 1 an Department of Heal Important: If item 2 any holyry or other once.		20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) GARDENS OF FAITH 1/21		Location - City or Town, State LTIMORE, MARYLAND
Balti Permit. Departi Importe any loju		21. Signature of Funeral Service Licensee . 22. Name and Address of Facility CH 6224 EASTERN AVE.,	IARLES S. Z BALTIMORE	ZEILER & SON, INC. E, MARYLAND 21224
Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	or respiratory arrest,	Approximate Interval Between Onset and Death
8760, cate be executed by sticien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Linter underlying Cause (Disease or righry that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	with Pe	Citoritis
O. Box 6 ne death certifications in the attending in the deference as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 morphs? 1		23d. Date of delivery Month Day Year
Cords, P.(wrequires that the been signed by should be detace	d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death? 2 □ No 3 □ Probably 4 Ø Unknown
Vital Recordicion: The law requicantificate has been rector, page 2 should	e Completed	25. Was case referred to medical 26. Place of Deat	24a. Was an autopsy performed	
of Vita Physiclen: this certific	To B	examiner? Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	th Check onl one ome 5 ☐ Residence	6 □Other (Specify)
ision c trending P death. ctor: After i	ation:	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident State of Injury (Month, Day Year) 28b. Time of Injury 28b. Time of Injury Work? 1 Yes 2 No	28d. Describe how in	jury occurred
Division or To the Hospitel or Attending Physipher 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
ne Hospi n 24 houn ne Funer	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	, and due to the cause rred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
To the within To the company	×	29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number 29c. License number	29d. [Date signed (Month, Day, Year)
h		30. Name of address of person who completed cause of death (Item 23a) (Type, Print)	mole M	0 21237
Sta Registr	•	31. Date filed (Month, Day, Year) 32. Trigistrar's Signature AN 2 1 7005	, , , ,	

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Wilson 10:15a м James 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner NA 342 Bloom Street 3rd Floor Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1√2 M 2 □ F 218-42-6582 Director 60 4-2-44 Md Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Items 23a or 28a-f show the Medical Examinat must be notified at Yes 2 No Director Md. NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 342 Bloom St. 302 Apt. 21217 death Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after d il Hygiene. other then "natural", or Item 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) University Hospital 12th grade Nurse's Asst permit. Pages 1 end 2 should be filed Department of Health and Mental Hygic Important: If item 27 ie marked othern any injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Wilson Aslean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Wilkins 4930 Greencrest Rd., Baltimore, Md. Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 1-21-05 Greenmount Cem. Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. llol E. North Ave. Approximate Immediate Cause (Final disease or condition resulting in death) Caneer Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to to, as a consequence of Examiner use as the burial-transit and Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. | 1 ☐ Yes 2 ☐ No detached 9 Unknown 2 been signed be should be deta ther significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? eath but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown Yes Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica 25. Was case Be 26. Place of Death (Check only one) Other: 4 Nursing Home 2 No 5 Hesidence 6 □Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menner of Death

1 ★ Natural

2 □ Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d, Date-signed (Month, Day, Year) 29b. Signa SOUTH GREENE STREET State Registrar

			1 - For State Registrar	State of M	arylar	nd / Depa	artmer	nt of Healt te of Dea	h and M	lental Hy		2005	01447	7
	٥٠.		1. Decedent's Name (First, Middle,	Last)						2. Date of De	ath		3. Time of Death	_
	Physici /Medi		Evelyn	M.		V	Vicks			Month	Day		5 1:04PM	A
	Examir		4a. Facility Name (If not institution,	give street and number)			4b. City,	Town, or Locati	ion of Death			County of Death		-
			Franklyn Son	lare Hos	ni ta	1	R	oseda	10		B	altimi	Tre	
	Funeral		5. Social Security Number	6. Sex 7. Ag	(In yrs.	last birthday)	If Under	r 1 Year If Un		8. Date of Birt	h	9. Birth	nplace (State or Foreign untry)	n
ь	Director		220-76-1005	1 □ M 2 🛣 F	9	91 Yrs.	Months	Days Hou	ırs Min.	8. Date of Birt (Month, Da April 1	0,19	13 MD	untry)	
	pu ,		Usual Residence of Decedent											
	show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits	
	Ba-f	ct	MD. Balti	more		Dunda	alk						1 □ Yes 2 No	3
	ath with the Marylan s 23a or 28a-f show wat by notified at	Funeral Director	10e. Street and Number				10f. Zip	Code			10g. Citi	zen of What Co	untry?	
	ath w	<u>ra</u>	206 Robwood Roa	d			2	1222			US	A		
7	tems	une	11. Marital Status	12. Was Decedent Armed Forces?		l.S. 13. \	Was Dece f Yes, spe	dent of Hispanic cify Cuban, Mex	Origin? (Specican, Puerto	cify Yes or No- Rican, etc.)		 Race - Amer Black, White 		
99	s afte	by F	1 ☐ Never Married 2 ☐ Marrie 3 🖫 Widowed 4 ☐ Divorced	If Yes, Give	No		1 □ Yes							
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show office Ever, liver in the notified at	d b	21	Year or Dates:		1 10 0						4411	ite	
5	c * a	Completed	15. Decedent's (Specify only highest			(Give	tent's Usua kind of wo DO NOT u	al Occupation rk done during r	most of worki	ng	16b. Ki	nd of Business/I	ndustry	
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20	be filed withi tal Hygiene. d other than evant, It e M	e Cc	6 years 17. Father's Name (First, Middle, L.	ast)		Hous	sewife		other's Name	(First, Middle,		wn Home		_
an	ould be Mental arked o	o Be	George Finan						Lula K		Maidell	Surrame)		
\geq	should be filed withind Mental Hygiene. marked other than matic event, ILEM	ř	19a. Informant's Name/Relationshi	n (Time Briet)		10h 14-10-					0:			_
Maryland	nd 2 sho alth and 27 Is ma r trauma		Agnes Carter	Daughter				od Road				Town, State, Z	ip Code)	
	Tegenthe		20a. Method of Disposition	Daugiteer	20b. F	Place of Dispo:	sition (Nar	ne of		_		cation - City or T	our State	_
Baltimore,	0 0		1 ☐ Burial 2 X Cremation 3			cemetery, cren	natory`or o	ther place)	Janua	_				
Ţ.	rtmer rtant rtant njury		'4 □Donation 5 □ Other (Special)		Day	yview C		_				imore C		
Bal	permit. Page Department Important: If any injury of once.		21. Signature of Fundral Service Li	censee	00	$\frac{22}{C}$	Name and Onne.	d Address of Fa Lly Fune	eral Ho	ome Of	Dund	alk,P.A alk,Md.		
	402 40		grany	Conne	RE	× 7	7110 5	Sollers	Point	Road,	Dund	alk,Md.		
			23a. Part1. Enter the disease or c shock, or heart failure. List of	omplications that caused by one cause on each li	the deat	Do not ente	er the mod	e of dying, such	as cardiac o	r respiratory ar	rest,		Approximate Interval Between	
	Priysician		Immediate Cause (Final disease or condition resulting in death)	_a -ata	(arrhi	thi	mia					Onset and Death	
1	/Medical Examiner		resulting in dealiny	Due to (or as	a conseq	uence of):								
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, –	ed sit	ine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a conseq	uence or):								
_	and and I-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consec	nence of):								
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	<u>a</u>		233 10 (0. 43	a oonooq	uunuu un.								
87	physic physic the k	g	·	d								-		
9 ×	eath certifica attending ph I for use as th	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	ancu/								
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	I death 3	Ectopic pr				2	3d. Date of delive Month	rery Day Year	
o.	the d	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	time of a	eath 5	Other (sp	өспу)					•	
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ds,	signed h	d by					,	giroi, iir.		1 🗆 Y		,	bably 4 Unknown	
Š	w require been sig should b	Completed										4		_
æ	e la has	mpi								24a. Was a autop	sy	prior to co	opsy findings available empletion of cause of	
al la	The ate	Co								perfor 1 ☐ Yes	2 No	death? 1 ☐ Yes	2 No	
Z.	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Literation					ace of Death	Check only or	18)			
of	this al dii	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie		ER/Outpatient						□Other (Speci	fy)	
Ü	ding I h. After funer	on:	27. Magner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	Year)	28b. Time of Injury		8c. Injury at Work?		8d. Describe h	ow injury	occurred		
Sign	Attanding r death. sctor: After by the fune	cat	2 Accident investiga 3 Suicide 6 Could no	t bo			М	1 ☐ Yes 2						
Division of Vital Records,	or Al	Certification:	4 Homicide determin	ed 28e. Place of Inju- building, etc	. (Specif	ome, farm, stre y)	et, factory	, office	2	8f. Location (S City or Tow	treet and n, State)	Number or Run	al Route Number,	
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	2	20a Cartilia-	District The Control of the Control										
	Hos 24 ho Fun Fun	edicai	29a. Certifier 178 Certifying (Check only 2 Medical Exone)	Physicien: To the best commer: On the basis of	examina	wledge, death tion and/or inv	occurred a estigation,	at the time, date in my opinion, o	and place, a death occurre	nd due to the c d at the time, c	ause(s) a late and	and manner as s place, and due t	stated. o the cause(s)	
	o the ithin o tha mple	Mec	29b. Signature and title of certifier	and manner sta	iled.			. License numbe				signed (Month,		
	F 3 F 8		1 d	100.							.y /	1 /		
	1.	-	denn	15	>		١	0055	5-13		1/	21/200		
	X		30. Name and address of person w	1. Chart	eath (Item . i/ i	0	rint	ve Bal	L	1112	121	7		
	Sta	to	31. Date filed (Month, Day, Year)	32 Registra	r's Signa	J9UAR	DI	ve Dal	mmore,	MU 21	20			_
	اد Registr ب	_	-IAN 2 1 2	8	. 1	& Son	13							

			For State Registrar	State of N	Marylan		artment rtificate			and M		jiene	005	011	448
	Physicia /Modic		1. Decedent's Name (First, Middle, Las Kim-Marie Wa							1	2. Date of Dea Month January	th Day	Year 2005	3. Time o	
	/Medic Examin		4a. Facility Name (If not institution, give Holy Cross Hospita		er)		4b. City, 1		ocation o	f Death		4c. Cou	nty of Death	-1	
	Funeral Director		5. Social Security Number 6. Se 076-68-2507		Age (In yrs.	last birthday) 5 Yrs.	If Under		If Under 2 Hours		8. Date of Birtl (Month, Day Oct. 7	Year)	9. Birth	place (State	or Foreign
	Maryland s-f show	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgor	mery		y,Town orLo								10d. Inside 0	City Limits
	3a or 28e	al Direc	10e. Street and Number 12906 Tourmaline				10f. Zip		~			10g. Citizen	of What Cou	ntry?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 Is marked other then "netural", or Items 23a or 28e-f show amy injury or other treumatic event, the Mudical Exertinating and the notified at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	is? ⊠No			ent of His ify Cuban	panic Orig , Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	14. F	Race - Ameri Black, White,		
21215-0036	d within 72 ho jiene. r then "natur the Medical.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		or 5+)	(Give	dent's Usual kind of work DO NOT use	k done du	ion <i>iring</i> most	t of w orkir	ng		f Business/Ir w Firn		
Maryland 2	ould be filed Mental Hyg wrked othe	To Be C	17. Father's Name (First, Middle, Last) Arthur Marsh						Darl	Lene	(First, Middle, Huger				
e, Mar	l and 2 sh lealth and im 27 is m her treum			_{Уре, Print)} (Uncle)	205 0	6276	Marti	n Ro		Colum	Route Numbe	ary1an	d 2104	44	
Baltimore,	Pages 1 Iment of H tent; If Ite Jury or ott		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	')	te Mar	Place of Dispo Cometery, crei Y Land Letery	Natio	na I		1-22-	-2005		on - City or T		
Ball	Departiment Depart		21. Signature of Emeral Service Licen	Mol	280	55	55 Tw	in K	nolls	s Roa	s, Inc.		_Mary]		
	Physician /Medical		23a. Part1. Entiff the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Brea	h line.	ncer w					r respiratory ari	rest,		Approxima Interval Be Onset and	tween
8760,	death certificate be executed be extending physician and and for use as the burial-transit														
.O. Box 6	death certi e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	1 2 ☐ Feta tat time of d	I death 3	Ectopic pre Other (spe						Date of deliv Month	ery Day	Year
α_	w requires that the been signed by the should be detache	by	Part II. Other significant conditions of	ontributing to deat	h but not res	ulting in the u	nderlying ca	tuse giver	n in Part 1.		23e. Did to	bacco use c		he cause of	
al Records,	The law ate has b page 2 st	Completed								-	24a. Was a autop perfor 1 Yes	sy	b. Were auto prior to co death? 1 ☐ Yes	mpletion of	available cause of
ion of Vital	Attending Physician: The rideath. ector: After this certificate by the funeral director, pag	tion; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation		-	ER/Outpatier 28b. Time o Injury		A Other Bc. Injury Work?	4 □ Nui	rsing Hon 2	(Check only of ne 5 Resid 8d. Describe h	ence 6 🗆 (fy)	
Division	Dir.	Certification;	3 Suicide 6 Could not be 4 Homicide determined	280. Place of	Injury - At he etc. (Specif	ome, farm, st	eet, factory,	, office		2	8f. Location (S City or Tow	treet and Nu n, State)	mber or Run	al Route Nur	n <i>ber,</i>
	the Hospitel hin 24 hours a the Funerel I npletely filted	edicai	29a. Certifying Ph (Check my 2) Medicel Exam	ysician: To the be niner: On the basis and manner	s of examina	wledge, deat ition and/or in	h occurred a vestigation,	at the time in my opi	nion, deat	d place, a th occurre	and due to the ded at the time, o	ause(s) and late and plac	manner as s ce, and due t	itated. o the cause(s)
)	To the within 2 To the complete	2	29b. Signature and title of certifier	AAMIR	μŧ			D5!	9284			29d. Date sig	ned (Month,	Day, Year)	
	U			500 Fores	st Gle	n Road		ver :	Sprin	ng, M	[aryland	1 2091	0		
	Sta Regist		31. Date filed (Month, PAN 2 1	2005 32. Re	strar's Signa	ture /	Coule	1							

			For State Registrar	State	of Marylar	•	artment of F		and Mental H	ygiene Reg. No	2000	Alle
T	Physici	an	1. Decedent's Name (First, Midd.	e, Last)				_	2. Date of D			3. Time of Death
	/Medic		Mary	Louise		Wats			Januar	y 17	2005	12:17 p M
	Examin	ner	4a. Facility Name (If not institution 5967 First S	-	umber)		4b. City, Town, o	or Location o	of Death	1	County of Deati	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Deale If Under 1 Year	If Under 2		lirth	Anne Aru	
	Director		578-30-9125	1 □ M 2 📉 F	7	6 Yrs.	Months Days	Hours	June 5	(192) 192	28 Wash	nplace (State or Foreign untry)
	pu 🔻		Usual Residence of Decedent 10a. State 10b. County		100 0	ty, Town or Lo	nanting					10d. Inside City Limits
	Aaryla F sho	ō					Cation					1 ☐ Yes 2/17No
	28e-	Director	MD Anne 10e. Street and Number	Arundel		Deale	10f. Zip Code			10a, Cit	izen of What Co	
	38 of	Ö	5967 First St	reet			207	51			USA	
	death	Funeral	11. Marital Status		cedent Ever in U	J.S. 13.			gin? (Specify Yes or N , Puerto Rican, etc.)	10-	14. Race - Amer	
2-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show any njury or other treumatic event, the Medical Evantinal must be notified at anones.	by	1 ☐ Never Married 2 ☐ Mar 3 📉 Widowed 4 ☐ Divorced	ried 1 ☐ Yes	2 XNo ive	1			, r deno modn, etc.)		Black, White	White
ה	natu	Completed		t's Education st grade completed)	(Give	dent's Usual Occup kind of work done	during most	of working	16b. K	ind of Business/l	ndustry
V	within ane. then	dm	Elementary/Secondary (0-12)	College	(1-4or 5+)	Mana	DO NOT use retire	a)			Danharra	
D	filed Hygid Sther ent,	ပိ	17. Father's Name (First, Middle,	Last)		Hana	igei	18. Mother	r's Name (First, Middi	le, Maiden	Restaur	ant
and	lid be lental rked ric ev	To B	Louis Marucci					Hele	en M. Walk	er		
ary	and N		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Street	and Number	r or Rural Route Num	ber, City o	or Town, State, Z	ip Code)
Σ 	and 2 ealth m 27 I		Richard Sacch	ino (Brot					Forestvill			
ore	ges 1 t of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation	3 Removal from	20b.	Place of Dispo cemetery, crea	osition (Name of matory or other plac		Date		ocation - City or 1	
Saltimor	t. Partmen		`4 □Donation 5 □ Other (S	pecify)			ematory		1/21/2005	Balt	imore,	MD
0	Depriming Depriming Indiana		21. Signature of Funeral Service	20000000		2		Fune	ral Home,			
	A 40 113		23a. Part1. Enter the disease, o shock, or heart failure. List	Diplications that	caused the dea	th. Do not en	12 Kidge er the mode of dyir	Ly Ave	enue, Anna cardiac or respiratory	polis arrest.	. MD 21	Approximate
	Physician		Immediate Cause (Final	only one cause on								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a	(or as a consec	quence of):	Renal T	CCITCCI				6-12 mer
	Examiner		Sequentially list conditions, b. Nerhosclerosis									year
	sit ad	Iner	Bany, leading to immediate Due to (or as a consequence or).									1
_	cate be executed physician and the burial-transit	Examin	that initiated events resulting in death) Last	c. John Due to	(or as a consec	mence of).	Cardino	agens	ch Digital	1.6		yeur
0/0/0	sician buria	dlcal E			,	,						
000	The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the			d								
X O O	w requires that the death certific been signed by the attending pl should be detached for use as i	hysiclan/Me	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		Ectopic pregnancy	v		4	23d. Date of deliv	•
	e dea the att	sick	in the past 12 months? 1 Yes 2 No		nant at time of o		Other (specify)	,			Month	Day Year
ŗ	hat th od by detach	۵.	9 Unknown Part II. Other significant conditi	ons contributing to	death hut not res	sulting in the u	nderlying cause an	en in Part I	23a Did	tobacco u	ise contribute to	the cause of death?
ů,	signe d be	d by	Hyperparenthy			_	ridariying cause giv	real littrail (t.		Yes 2		bably 4 Dunknown
ecords,	w requ	lete	Chronie Obstru	Arre Pinh	andread N.	Arean	0		24a. Wa			opsy findings available
Ě	The lay	Completed		ohn's D		District			aut	opsy formed?	prior to or death?	ompletion of cause of
V 11/2	ding Physicien: The lav h. After this certificate has funeral director, page 2	0	25. Was case referred to medica		MECHE			26. Place	of Death (Check only		1 Yes	2 No
>	nysici nis cer direc	To B	examiner? 1 □ Yes 2 ☎ No	Hospital: 1	Inpatient 2	ER/Outpatier	nt 3 DOA Oth		rsing Home 5 X 1 es		6 □Other (Spec	ify)
5	ng Pł		27. Manner of Death 1 Natural S □ Pendin	28a. Date (Mor	of Injury oth, Day Year)	28b. Time o Injury	28c. Injur Wor		28d. Describe			
JIVISION	tendi death. tor: A the fu	ertification:	2 Accident investi	gation				Yes 2□N				
\leq	or All	ertifi	4 Homicide determ	ined 286. Plac	e of Injury - At n ding, etc. (Speci	ome, farm, str fy)	eet, factory, office		28t. Location City or To	(Street an own, State	d Number or Rui)	al Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director,	O	29a. Certifier 1 X Certifyin	ng Physician: To th	e best of my kno	owledge, deat	occurred at the tir	ne. date and	d place, and due to the	e cause(s)	and manner as	stated
	n 24 h	edical	(Check only 2 Medical one)	Examiner: On the I	basis of examina nner stated.	ation and/or in	vestigation, in my o	ppinion, death	h occurred at the time	, date and	place, and due	to the cause(s)
	To the comp	Ž	29b. Signature and title of certifie	_			29c. Licens		_	29d. Dat	e signed (Month,	Day, Year)
	λ		· Oerald	P. Ster	men p	1. D.	DI	2745		Jan	nuary 1	9,2005
	4		30. Name and address of person	100				- La		MD 2	0726	
	Sta	to	Gerald P. Ste	rner, MD	Resistrar's Signa		е веасп	ra., E	. Uwings,	MD 2	U/36	
	Registr	rar	31. Date filed (Month, Day, Year,	2005		4	0					
DHI	MH 17 Rev 1/2				leen.	0	THE PARTY OF THE P					
						ORIGINA	AL					

			1 - For State Registrar		Marylan		artment of rtificate o				giene Reg. No. 2005	5 01450		
ı	Physicia	an	Decedent's Name (First, Middle, La ARIE CLEVELAND	•	ORE					2. Date of Dea	Day Yea 20,2005			
	/Medic Examin		4a. Facility Name (If not institution, gire				4b. City, Town	n, or Location		DANOAKI	4c. County of De	11:25 AM		
			CONTINUUM CARE A					SVILLE ar If Under	OA Hee		CARROLI			
	Funeral Director			Sex M 2□F	. Age (In yrs. 77		If Under 1 Ye Months Day		Min.	8. Date of Birt (Month, Dat OCTOBE	R 4,1927	irthplace (State or Foreign Country) MARYLAND		
	סי		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	ncation					10d. Inside City Limits		
	Maryla -1 shor	ō	MARYLAND CARRO	LL	100.01	WESTM						1 Yes 2 No		
	th the or 28a e rolli	Director	10e. Street and Number				10f. Zip Cod				10g. Citizen of What	Country?		
	s 23a	ral	719 LONGVIEW AVE	.,	- A Francis II	6 10	2115		ining (Con		UNITED STA			
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Itam 27 is merked other than "natural", or Itams 23a or 28a-f show or other traumatic evant, the Medical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deced Armed For 1 1 Yes If Yes, Give	dent Ever in U ces? 2 □ No tes: KOREZ	.5.	Was Decedent of If Yes, specify C 1 ☐ Yes 2 🔯 N			cry Yes or No- Rican, etc.)		nerican Indian, nite, etc. /HTTE		
21215-0036	72 hou natura lical E	ed	15. Decedent's E (Specify only highest gr	ducation		16a. Dece	dent's Usual Oc	cupation	et of workin	ng	16b. Kind of Busines			
121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-	4or 5+)	life.	DO NOT use ret	rired) ERINTEN			CONSTRUC	TTON		
	illed I Hygie othar	Be Co	17. Father's Name (First, Middle, Las							(First, Middle,	Maiden Sumame)	TION		
ylar	2 should be filed withir and Mental Hygiene. Is markad othar than aumatic evant, the Ms	ToB	JOSEPH T. WHITMOI							HNSON				
, Maryland	1 and 2 sh Health and am 27 Is m		19a. Informant's Name/Relationship HELEN O. WHITMOR								oute Number, City or Town, State, Zip Code) NSTER, MD 21157			
Baltimore,	permit. Pages 1 and Department of Health Important: If Itam 27 eny injury or othar tr once.		20a. Method of Disposition 1X Burial 2 □ Cremation 3 [14 □ Donation 5 □ Other (Speci		tate	semetery, crei	osition (Name of matory or other p NEM GA	place)		ate 24/2005	20c. Location - City of FINKSBURG	or Town, State MARYLAND		
Balti	permit. Pag Department Important: eny injury o		22. Name and Address of Facility MYERS-DURBORAW FUNERAL HOME, P.A. 91 WILLIS STREET, WESTMINSTER, MD 21157 Approximate Approximate											
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that ca	used the deat ich line.	h. Do not en	er the mode of	tying, such as	cardiac o	r respiratory ar	rest,	Interval Between		
Physician Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death)											Onset and Death			
	Examiner			Due to (or as a conseq	uence of):								
	pe #s	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq									
Ć,	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence ol):	lestel	gua						
8760,	ate be execu hysician and the burial-tra	dicai		_ d(SER	D_								
Box 6	death certific e attending p id for use as t	√Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo			_				23d. Date of c	lelivery		
P.O. B	the d	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2 ☐ Feta ant at time of d wn		DEctopic pregna Other (specify,				Month	Day Year		
Division of Vital Records, F	w requires that the been signed by the should be detached	Completed by P	Part II. Other significant conditions	contributing to de	ath but not res	ulting in the u	nderlying cause	given in Part	l. 	23e. Did to		to the cause of death? Probably 4 Unknown		
eco	~ Q 76	nplet		,						24a. Was autop	osy prior t	autopsy findings available completion of cause of		
al H	rician: The law certificate has rector, page 2 s		OS Was area relevant to madical							1 Yes		es 2 No		
f Vii	Physician: this certific ral director,	To Be	25. Was case relerred to medical examiner? 1 Yes 2 No	Hospital:	npatient 2	ER/Outpatie	nt 3 DOA	Other		<i>(Check only o</i> ne 5□Resid	one) dence 6 ∏Other (S	pecify)		
o u	ding Phys h. After this funeral di		27. Manner of Death 1 Death 5 Pending		f Injury n, Day Year)	28b. Time o		njury at Work?	2		now injury occurred			
/isio	Attand death actor: /	Certification;	2 Accident investigate 3 Suicide 6 Could not determine	be 28e. Place	of Injury - At h	ome, farm, st	M 1 reet, lactory, offi	l ☐ Yes 2 ☐ ce			Street and Number or	Rural Route Number,		
Ö	rs after rs after al Dira	Certi	4 Homicide	buildir	ig, etc. (Specil	(y) 				City or Tov	vn, State)			
	To the Hospital or Attanding Pi within 24 hours after death. To tha Funeral Diractor: After the completely filled in by the funera	edical	29a. Certifier 1 Certifying F (Check only one)	hysician: To the miner: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurred at the vestigation, in m	e time, date ar ny opinion, dea	nd place, a ath occurre	and due to the ed at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)		
N	To the To the Comp.	Ĭ	29b. Signature and title of certifler	VALOR	1 1	ND		ense number	742		29d. Date signed (Mo			
	/X\		30. Name and address of person who	completed cause	ol death (Iter	11 23a) (Tvna		000	72	18	01-21-	03		
_	Ŋ,		RAMAN KANERIA M.I	439	MALCO	LM DRI		STMINS	TER,	MD 21	1157			
	Sta Regist		31. Date filed (Month Par, Year)	2005 32.	gistrar's Signa	The A	pode							

			For State Registrer		State	of Ma	ryland /		artmen rtificate				lental I	Hygie Reg	5- V	05	014	51
	a		1. Decedent's Nam	e (First, Middle	, Last)								2. Date of		-		3. Time of I	Death
	Physici /Medi		Florenc	ce M.	Wilkens								JANU.	ARY	14, 1	2005	1:15p	М
	Examir		4a. Facility Name (I			umber)					Location (nty of Death	1 2.130	
	Funeral Director		5. Social Security N 213-32-2		6. Sex 1 ☐ M 2 ☐ F	7. Age	(In yrs. last t	virthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of (Month) JUNE	Birth Day, Yo	ear) 1935	Cour	place (State or stry) svlvani	
	pu ,		Usual Residence of			-							0.12					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event. The Medical Examinar must be notified at Once.	Funeral Director	10a. State MD	10b. County Howar	d		10c. City, To Elk	ridg									1 Yes	·
	or 28	Jire	10e. Street and Nu	mber					10f. Zip	Code				10g	. Citizen o	of What Cour	ntry?	
	23a	la	6391 Rot	wanberr	y Drive,	Apt.	. 218		21	075					USA			
	r deg	ne	11. Marital Status		12. Was De Armed F	orces?		13.	Was Deced	ent of Hi	spanic Ori	igin? (Spe	ecify Yes or Rican, etc.	No-		ace - Americ		
36	s afte	by Fi	1 Never Marr 3 Widowed	_	If Yes, G	2X No	0		1 ☐ Yes 2		Specify:				Spec		ite	
ô	hour tural	pa p	3 🗆 Widowed	15. Decedent	Year or	Dates:	16				tion			1 10	h Kind of			
15	in 72 n na n na	olet		cify only highes	t grade completed			(Give	dent's Usua kind of wor DO NOT us	k done a e retired	luring mos	t of work	ing	16	D. King of	Business/In	dustry	
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	i Hyg othe	a	17. Father's Name	(First, Middle,	Last)				451110	<u>-</u>	18. Mothe	er's Name	e (First, Mic	idie, Mai			CD11	
lar	Aenta Venta rked IIC ev	To B	Raymond	i Roger	son							Mae	Messi	ck				
Maryland	shot and N		19a. Informant's N				19	b. Maili	ng Address	(Street a	and Numbe				ity or Tow	m, State, Zip	Code)	
	and 2 valth v27 i		Sheila N	Miller	- daughte	er						Jes	ssup,	MD	2079	14		
ore	of He of He fiten r oth		20a. Method of Dis	•	2 Dameus lásas	n Ctata	20b. Place cemet	of Dispo	sition (Nam	ne of ther place	9)	- [Date	20	c. Location	n - City or To	own, State	
Ĕ	Pag nent ent: I		`4 □Donation		3 □Removal from pecify)	n State	Balti				1	1/19	/2005		Laure	el, MD)	
Baltimore,	permit. Depart Import any inj		21. Signature of F	neral Service	Licensee			Ge	Name and Ty L.	d Addres Kai	ifman	Fun	eral i	Home Ikri	@ Mea	adowri	.dge MP,	Inc.
	1000		23a. Part1. Enter t shock, or hea	he disease, or	complications that	caused t	the death. Do									110	Approximate Interval Betw)
1	Physician /Medical Examiner		Immediate Cause disease or condition resulting in death)	(Final on	a. And	8140	consequenc	otic						900			Onset and D	
	uted I	Examiner	Sequentially list co cause. Enter Unde Cause (Disease or that initiated events	enditions, in ediate erlying injury	b. Due to	o-(oras a	nonsequario	alot):										
Ć,	cate be executed physician and the burial-transit	Exa	resulting in death)	s Last	C. Due to	o (or as a	consequenc	e of):			-					_		
8760,	ysicia ysicia e bur	dlcal			d													
9		4 0	termina a															
.O. Box	The law requires that the death certificate has been signed by the attending processes 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 21 9 ☐ Unknown	months?		birth 2 gnant at ti	f pregnancy 2 Fetal dea ime of death		Ectopic pre Other (spe					_		Date of delive Month	-	ear
S, P	es that gned t	by P	Part II. Other signi	ficant condition	ns contributing to	death but	,0			_ T -	n in Part I		23e. D	oid tobac	co use co	ntribute to th	ne cause of de	eath?
brd	w requir been si should	ted	Chpor	UR O	bsome	ひくら	- rul	عمان	Myn	1)1	747	5	1	□ Yes	2 🗆 No	3 🗆 Prob	ably 4 □U	TKnown
Records,	The law rate has by page 2 sh	Completed								<u>.</u>			24a. V a p 1 2 Y Y €	utopsy erforme	d?	prior to con death?	psy findings a mpletion of ca 2 No	ivailable luse of
Vital	vicien: Th certificate rector, pag	BeC	25. Was case references	rred to medical							26. Place	of Death	(Check or		1110		20.00	
of V	d is	10	1XXes 2	No	Hospital: 1	Inpatien	t XXER/C	Dutpatier	it 3□ DO	A Othe	ar: 4□ Nu	rsing Ho	me 5 🗆 F	lesidenc	e 6 🗆 O	ther (Specif	y)	
0	ding Ph h. After th funeral		27. Manner of Dear	th 5 🗌 Pendin		e of Injury onth, Day	Year) 28b	. Time o	2	Bc. Injury Work	at		28d. Descri	be how	injury occi	urred		
sio	Attending or death. ector: After by the fune	cati	2 Accident	investig	ation				М	-	/es 2□	No						
Division	tel or At rs after d el Direct ed in by	Certification:	3 Suicide 4 Homicide	determ	ined 288. Plac	ce of Injur ding, etc.	ry - At home, (Specify)	farm, sti	eet, factory	, office				on (Stree Town, S		nber or Rura	I Route Numb	D⊕ <i>r</i> ,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical	29a. Certifier (Check only one)	1 Certifyin	g Physician: To the Examiner: On the and ma	ne best of basis of e inner state	examination a	ge, deat and/or in	occurred a vestigation,	at the tim in my op	ie, date an pinion, dea	d place, th occurr	and due to ed at the tir	the caus	e(s) and r and place	nanner as s	tated. the cause(s)	
	To t To t	Ž	29b. Signature and	divide of certifier	mello	222	Mo		290	. License	number CME				_	ned (Month, Y 16,		
	9		30. Name and add	ress of person	4.0	use of dea				REET	BAL	TIMO	RE,MAI	RYLA	ND 21	1201		
	Sta Regist	ate rar	31. Date filed (Mor		32.	Paistrar	r's Signature				<u> </u>							

			For State Registrar	State of Ma	aryland /		nent of He cate of D	ealth and Moeath	_	giene 005	01452	
	Physici	an	1. Decedent's Name (First, Middle, Helen Rose W						2. Date of De Month	eath Day Year	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution,	give street and number)	tospit	0-1 K	0300	Location of Death		19 2005 4c. County of Dea	1 7:10HM	
-	, Funeral Director		5. Social Security Number 213–09–6686	5. Sex 7. Ag 1 ☐ M 25☐ F	e (In yrs. last bi		Inder 1 Year oths Days	Hours Min.	8. Date of Bir (Month, Da 7/18/		thplace (State or Foreign buntry) ryland	
	ryland how		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov	vn or Locatio	1				10d. Inside City Limits	
	death with the Maryland ms 23a or 28a-f show r nust be nutitied at	rector	MD N/A		Balti		f. Zip Code			10g. Citizen of What Co	1 ⊠Yes 2 □ No	
	th with 23a or 51 be	al DI	6422 Rosemont A	venue			21206	6		U.S.a.	ourity r	
اب 036	after or ite	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? Id 1 Yes 2 1 1 Yes, Give Year or Dates:			Decedent of His specify Cuban es 2 X No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		e, etc.	
Leleh 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", any injury or other traumatic event, the Medical Exu once.	npleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4or 5		(Give kind life. DO N		tion uring most of worki	ing	16b. Kind of Business	findustry	
d 21	filed w Hygier Sther ti ent, th	e Col	9 17. Father's Name (First, Middle, L	ast)		House		18. Mother's Name	(First, Middle	Own Home Maiden Sumame)		
ylan	should be nd Mental marked c	To Be	William Hannema					Anna Sc		,		
∩ o n Mary	nd 2 sh Ilth and 27 is m r traum		19a. Informant's Name/Relationsh Ruth Kraus/Daug							er, City or Town, State, I re, Maryland		
ore,	jes 1 ar of Hea If item 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal from State	20b. Place o	of Disposition ary, cremator	(Name of or other place,	,	ate	20c. Location - City or	Town, State	
√ , \	nit. Page artment ortant: If ortant: If injury or		* 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L	ecify)	Park		ne and Address	1/24 of Facility M 1 1		Baltimore, ppel Funeral	Maryland	
	permit. Departr Importa any inji		Valin 1			6415	Belair	Road Ba	1timore	, Maryland	21206	
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Due to (or as a consequence of):									
68760,	Attending Physician: The law requires that the death certificate be executed reath. reach. sctor. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.									
.O. Box 68	that the death certifica ed by the attending pt detached for use as t	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		pic pregnancy or (specify)			23d. Date of del Month	ivery Day Year	
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f Viit	yalcian: tis certifica director, I	To Be	25. Was case referred to medical examiner? 1 Tyes 2 No	Hospital:	ent 2 ERVO	utpatient 3	DOA Other	 Place of Death 4 ☐ Nursing Hor 		dence 6 Other (Spec	city)	
o uo	ding Ph h. After thi funeral		27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investige		ry 28b. y Year)	Time of Injury	28c. Injury a Work?	at 2 ? es 2 □ No	28d. Describe I	how injury occurred		
Divisi	al or Attendi s after death. Il Director: A	Certification;	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not determine	ot be	ury - At home, fa c. <i>(Specify)</i>				28f. Location (S City or Tov	Street and Number or Ru wn, State)	ral Route Number,	
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by the	edical	(Check only 2 Medical E	Physician: To the best xaminer: On the basis of and manner sta	f examination ar	e, death occu nd/or investig	rred at the time ation, in my opir	o, date and place, a nion, death occurre	and due to the ed at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)	
		W	29b. Signature and the of certifier				29c. License	5202		29d. Date signed (Month	n, Day, Year)	
	3		30. Name and oddrass of per on w	Ker 9000 F1	CONKI	10 50	1110	e Dave		timore	m) 21237	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Segistro	ar's Signature	Span	<i>\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\</i>	1				

MICHAEL ZELAYA UNK 05-00354 05-00354 RPD **Physician** /Medical **Examiner**

Funeral

Director

28a-f ahov s 23a or 28a-f ahorust be notified at

the Medical Examiner

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permit. Page Department of important: if eny injury or once.

Pnysician /Medical

Examiner

Pages 1 ō = 5

other

filed within 72 hours after

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer 0 | 453 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15, 2005 Ruben Zelaya January 0108 A Michael 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 5810 Reisterstown Road Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days XIX M 2 F 21 Yrs. 214-04-3674 July 231983 Maryland Usual Residence of Decedent 10a, State 10b. Count 10c, City, Town or Location 10d. Inside City Limits XX Yes 2□No Funeral Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6960 Marsue Drive Apt. T1 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes **X**[X]No If Yes, Give XX Never Married 2 ☐ Married 1 ☑ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 Divorced Specify: white Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter $\operatorname{\mathsf{Enviromental}}
olimits \operatorname{\mathsf{Services}}
olimits$ 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ruben Zelaya Kimberly Ann Sands 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Ann Sands 6960 Marsue Drive Apt. T1 Mother Baltimore, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial XX Cremation 3 ☐ Removal from State Baltimore-Washington 1/21/2005 Laurel, Mar Grematery
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road Baltimore, MD 21211 4 Donation 5 Other (Specify) Laurel, Maryland 21. Signature of Funeral Service Liversee Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only due cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, loading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 X Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1∑ Yes 2 □ No 26. Place of Death Check onl one Other: $_{4\,\square\,\text{Nursing Home}}$ 5 \square Residence 6 (Specify) At Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Deceased She -15-05 12 midnight 2 Accident 3 🗌 Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number City or Town, State)

Hospital or Attanding Physicien: The law requires that the death certificate be executed burial-transit 68760 Box ò P.0. of Vital Records, After Division death. after death in by within 24 hours a

To tha Funaral C

completely filled is

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Parking 29a. Certifier 29b. Signature

Reisterstoan Rd. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainten as stated.

Medice! Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29c. License number O.C.M.E.

motel

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January 15, 2005

Batimone MD

person who to lead cause of death (Item 23a) (Type, Print) Street, Baltimore, Maryland 21201

State Registrar

Medical

31. Date filed (Month, Pay Year)

1-1

32. Reginar's Signature Elsen & Speck

			1- State Amend Item 24a per Verb., G839	partment of Health and I Office of Death	Reg.	4000 01494
E	Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Norman Edgar Ab:	recht Sr	2. Date of Death Month January 9	Day 2005 3. Time of Death 2:26pm M
7.	/Medic Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
H	Funeral		100 Burgess Hill Way, Unit 301 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd		8. Date of Birth	Frederick 9. Birthplace (State or Foreign
条	Director		220-10-5320	Months Days Hours Min.	Nov 9, 19	921 Maryland
	e Maryland	ctor	10a. State 10b. County 10c. City, Town of Maryland Frederick Frede			10d. Inside City Limits 1 ☐(Yes 2 ☐ No
	23a or 28	al Director	100 Burgess Hill Way, #301	10f. Zip Code 21702	10g.	Citizen of What Country? U.S.A.
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Important: If item 27 is marked other then "naturel; or items 23s or 28s-f show says injury or other treumstic event, Irs Madical Examiner must be notilised at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 XYes 2 No 1939— If Yes, Give Year or Dates: 1945	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert Yes 2 XNo Specify: 	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-0036	within 72 ho ene. then "natur	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	scedent's Usual Occupation live kind of work done during most of wor e. DO NOT use retired) ansportation Sectio		. Kind of Business/Industry Cederal Gov t
Maryland 2	ild be filed lental Hygir ked other ic event, I	To Be Co	17. Father's Name (First, Middle, Last)		me (First, Middle, Maid Mae	
, Mary	and 2 shou alth and M 127 le mai ar treumal			ailing Address (Street and Number or Ru Burgess Hill Way		ty or Town, State, Zip Code) erick, Maryland 2170
Jore,	ages 1, and of the in the or other		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	sposition (Name of crematory or other place)		Location - City or Town, State
Baltimore,	permit. Pa Depertmer Important eny injury		21. Sign jury of Funarat Service Licentee	ret Cemetery Jan 13 22. Name and Address of Facility Keeney & Basford	St. st. in the latest transfer	ederick, Maryland al Home
			23a. Part1. Enter the disease, of complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	106 East Church St enter the mode of dying, such as cardiac	Frederic or respiratory arrest,	al Home k, Maryland 21701 Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a	11	omeer	Onset and Death
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P.O. Box 68	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	Physician/Med		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		2 No 3 Probably 4 Unknown
Vital Records,	The ate h	Completed			24a. Was an autopsy performed	
I Vit	Physician: The this certificate har all director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	Othor	ath (Check only one)	6 ☐Other (Specify)
Division of	ding After fune		27. Manne-of Death 1 Natural 5 Pending (Month, Day Year) Injure 2 Accident investigation	e of 28c. Injury at	28d. Describe how it	
Divis	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	the Hospin 24 houth	ledicai	29a. Certifler (Check only one) 1 Certifying Physician: To the best of my knowledge, divided Physician: To the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	a, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To To Con	W	29b. Signature and title of certain MM	29c. License number D58391		Date signed <i>(Month, Day, Year)</i> nuary 10, 2005
-	-60			po. Print) Horase Are	, Fred	eriel, MD 21701
	Şta Registr		31. Data filed (Month, Pay, Year) 32. Registrar's Signature 2005	i e		

	-	For Stata Registrar	State of Maryl		artment of F			2000	01455
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/Medic	al	EFNES H 4a. Facility Name (If not institution, give st	exano	ier	,	r Location of Death	Januar		5 8:45 AM
Examine	er .	Baltimore VA	Medica	1 Center	Balt	IMOTE		4c. County of E	
Funeral Director		5. Social Security Number 6. Sex 064 · 18 · 255 i		yrs. last birthday)	If Under 1 Year Months Days			9. 1922 NI	Birthplace (State or Foreign Country) EW YORK
land bw	-	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	ocation				10d. Inside City Limits
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ns 23s	Funeral	VA MEDICAL CENTE	ZR BLDG 14 2. Was Decedent Ever	in U.S. 13.		902 dispanic Origin? (Si	pecify Yes or No-	USA 14. Race - A	merican Indian,
urs a urs	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 21 No	dispanic Origin? (Si an, Mexican, Puerti Specify:	o Rican, etc.)		/hite, etc. WHITE
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be filed htal Hyg ed othe event,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, i		T.VIXII
Maryland Z d 2 should be filed th and Mental Hygi ?? Is marked other traumatic event,	္ပင	ALEXANDRE BAILLI 19a. Informant's Name/Relationship (Typ		10h Maili	ng Addross /Street	ANNA L		r, City or Town, Stat	a Zin Codol
Ma nd 2 s alth ar 27 ts r trau		EDWARD ERNEST BAILI						=	S, NJ 07604
0 0		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re		b. Place of Dispo				20c. Location - City	
Baltimor permit. Pages Department of Important: If It any injury or o		'4 □ Donation 5 □ Other (Specify)	M	-	NS CEMET		3-2005		MARYLAND
Dermi Depa Impo any ji		21. Signature of Funeral Service Licenses	MERLER	3 /- 2	00 S. HAI	RRISON ST	'EASTON,	MD 21601	L HOME PA
700 00		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final	cause on each line.				or respiratory arr	est,	Approximate Interval Between Onset and Death
Pnysician /Medical	disease or condition resulting in death) a								2 days
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led sit	Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	Due to (or as a cor	nsequence of):					
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58760 icate be e physician s the buris	dlcal	d.							
Box 6 leath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pr					23d. Date of	delivery
Records, P.O. Box 68/60, The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit.	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 ☐ 4 Pregnant at time 9 Unknown		Dectopic pregnancy Other (specify)	/		Month	Day Year
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4ecord	Completed						24a. Was a autops	an 24b. Were	autopsy findings available to completion of cause of
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O & & E	-	27. Manner of Death	28a. Date of Injury (Month, Day Yea		" 3 DOX	4 Indishing h		ence 6 Other (5 ow injury occurred	рреспу)
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Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edical C	29a. Certifier (Check only one) 1 Certifying Physical Examination	cian: To the best of my er: On the basis of exal and manner stated.	knowledge, deat mination and/or in	h occurred at the till vestigation, in my o	me, date and place opinion, death occu	, and due to the corred at the time, d	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
To th withir To th comp	Me	29b. Signature and title of certifier	2107	1.7	29c. Licens	se number	2	29d. Date signed (M	
		- Which	1 Neels	- mi	> P/	4641		1-8-00	7
	_	30. Name and address of person who con WENDY A. WEEKS M.				ORE, MD	21201		
Sta Registr	-	31. Date filed (Month, Day 2 2005	2. Registrar's S	ignature	E)				

DHMH 17 Rev 1/2001

ORIGINAL

		State - State Amend Item 23a pe	r Dr.,G83	9,00	21/05dhb Tificate of L	Death)5 01450				
Physicia	ın	Decedent's Name (First, Middle, Last)					2. Date of De Month JANUAR		3. Time of Death				
/Medic	al	Mary Jean Bremen	aum bad		4b. City, Town, or	Logation of Dooth	DHIVUHK	4c. County					
Examine	er	4a. Facility Name (If not institution, give street and it Saint Joseph Medi	cal Cent	er	46. City, Town, or	TOWS	on		Baltimore				
Funeral Director		5. Social Security Number 6. Sex 115-18-7411 1□ M 2以 F	7. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Da May	th 1927	9. Birthplace (State or Forei Country) New York				
and *		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limi				
f show	٥	Maryland Harford		Aber					1 ∑X Yes 2 □ I				
28a	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhat Country?				
38 of	Ö	704 Webb Street			21001			USA					
permit. Pages 1 and 2 should be filed within 72 hours after death with fine maryland Depermit. Pages 1 and 2 should be filed within a file may be and Mental Hygiene. The promotents if filem 27 is marked other then "neturel", or items 23a or 28a-f show any injury or other treumetic event, the Madical Examinar must be notified at once.	by Funeral	11. Marital Status 1 Never Married 1 Never Married 1 Yes,	ecedent Ever in U.S Forces? s 25 No Give Dates:	'	Was Decedent of Hi f Yes, specify Cubai 1 ☐ Yes 2√2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Blac	e - Am <i>er</i> ican Indian, sk, White, etc. :: White				
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then "	dmo	Elementary/Secondary (0-12) College	(1-4or 5+)		ouse wife			In hor	ne				
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hental rked iic ev	To B	Martin Duffy				Juliett	e Fole	У					
and M		19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	ng Address (Street a	and Number or Rur	al Route Numb	er, City or Town,	State, Zip Code)				
alth a		William B. Bremen (hush	and)	704	Webb St.,	Aberdee	n, MD 2						
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Deperting any injury in	1	21. Signature of Funeral Service Licensee **LUSKO Anup()	nglesb	y A	arring-ca berdeen,	irgo Fune Maryland	ral Hom 21001-	e, P.A. 3399					
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vithir To th comp	Me	29b. Signature and title of certifier	0	_	29c. License	number 02263		29d. Date signe	d (Month, Day, Year)				
4,00		30. Name and address of person who completed co	ause of death (Item :	23а) (Туре.	Print)								
6		FRANCIS KHOO. M.D.	76/21	OSLE	RDRIVE	TOWSON.	MARYL	AND E1	204				
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			1- State of Maryland / Department of Health and M Certificate of Death		giene / Reg. No. ²	2005	01457							
п	- 14 7 5		Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of De	ath		3. Time of Death							
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	s 1 and 2 should if Health and Mer Item 27 le marke other traumatic		DERRICK BATTLE-SON 10302 BENDING BROOT 20a. Method of Disposition 20b. Place of Disposition (Name of	X WAY,			LBORO, ND Town, State 20772							
Baltimore,	0 0		VDYBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)											
≣		1 9	21. Signature of Funeral Service Licensee MO0479 = 22. Name and Address of Facility	-			MARYLAND							
ñ	permit. Departrimporte		RAYMOND FUNERAL LA PLATA, MARYI		ICE,									
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it.	Physician		shock, or heart failure. List only one cause on each line. Interval Between Onset and Death of the control of											
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Vital	rysician: Tr iis certificate director, pag	BeC	25. Was case referred to medical axaminer?				- 21							
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Ĕ	ding P. h. After funers	ii O	1 Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe	how injury	occurred								
Division of	Attending Physician: r death. ector: After this certific by the funeral director.	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location /	Street and	Number or R	lural Route Number,							
2	after 1 Dire	erti	4 Homicide determined building, etc. (Specify)	City or To										
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the red at the time,	cause(s) a date and p	nd manner a place, and du	s stated. e to the cause(s)							
	To th withir To th comp	Me	29b. Signature and title of certifier 29c. License number		29d. Date	signed (Mon	th, Day, Year)							
1		11	MD 34009		1/1	3/05								
	8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			,								
	0		KIDEST ASSEGUED, MD 1011 North Capitol St., NE 31. Date filed (Month, Day, Year) 32. R	Washi	ngto	n,DC_	20002							
	Sta Registra		JAN 2 1 2005 Bleen & Charles											

		For State Registrar	State of Marylan		artment of F rtificate of			ene 2005	01458
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Sarah Anderson	Burger		V		2. Date of Death Month JANUAR	Day Yeer	
Examin		4a. Facility Name (If not institution, give s Saint Joseph		ter	4b. City, Town, o	r Location of Deat		4c. County of De	ath ltimore
Funeral Director		217-26-6012	7. Age (In yrs.)	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, Aug. 22,	9. Bi	irthplace (State or Foreign Country) aryland
ene. than "natural", or liems 23e or 28e-f show he Medical Examinat must be notified at	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltimo		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2X No
3a or 28	al Director	10e. Street and Number 305 E. Joppa Rd.	, Apt. 903		10f. Zip Code 21286	5	10	g. Citizen of What C	Country?
ral', or items 23a or 28a-f show Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 🛣 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	i	Was Decedent of Hif Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Arr Black, Wh Specify: W]	ite, etc.
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arkad othar atic evant,	To Be C	17. Father's Name (First, Middle, Last) Albert I. Ande		1		Blanc	ne (First, Middle, M he Rhode	s	
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sician edical miner .		23a. Past?, Et r the disease, or complish k, heart failure. List only or Imm. Xet, Zause (Final diseas condition resulting in death)	c or respiratory arres	st,	Approximate Interval Between Onset and Death				
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tached for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of di 9 Unknown	death 3	Ectopic pregnancy Other (specify)	1		23d. Date of de Month	elivery Day Year
should be deta	by	Part II. Other significant conditions con	tributing to death but not rest	ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	1/	to the cause of death? Probably 4 Unknown
96 2	Completed						24a. Was an autopsy perform 1 Yes 2	prior to	autopsy findings available completion of cause of s 27 No
director, pag	o Be	25. Was case referred to medical examiner?	ospital: 1 Inpatient 2 🗆	ER/Outpatier	nt 3 DOA Oth	or	ath <i>(Check only one</i> dome 5 🗆 Residen		ecify)
itter th	ation; T	27. Manner of Death 1 A Natural 5 Pending 2 Accident investigation	28a. ate of Injury (Month, Day Year)	28b. Time of Injury	Wor	y at	28d. Describe how		
by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Stre City or Town,	et and Number or F State)	Rural Route Number,
To the Funeral Dir completely filled in	Medical	29a. Certifier 12 Certifying Physical Check only one) 12 Medicel Examination	sicien: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death ion and/or in	n occurred at the tirvestigation, in my o	ne, date and place pinion, death occi	e, and due to the cau arred at the time, dat	ise(s) and manner a e and place, and du	as stated. ue to the cause(s)
To tha complet	Me	29b. Signature and title of certifier	nella m.o		29c. Licens	e number	30	d. Date signed (Mor	nth, Day, Year)
6		30. Name and address of person who co	mpleted cause of death (Item	01 OS	Print)	VE TOWS	SON MARY	LAND 213	-014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 055 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** LLOYD BENCHOFF 2005 10 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ADVENTIST HOSPITAL IAKOMAPIL, MO MONTONIER WASHINGTON If Under Vear If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, Year)

Mar 11, 19 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 XM 2 F 49 Director **1**64-46-6875 PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ed other then "natural", or Itema 23a or 28a-f show event, the Medical Exemples must be rediffed at 1 Yes 2 No Director PA Franklin Greencastle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10536 Rabbit Road 17225 South USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 🔀 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 Is marked other then 'any rigury or other traumatic event, the Means once. Elementary/Secondary (0-12) College (1-4or 5+) Operations mgr. Waste mgmnt company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Benchoff, Jr. Mary Brake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorina J. Benchoff wife 10536 Rabbit Rd., Greencastle, PA 17225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 DXBurial 2 Cremation 3 Removal from State Cedar Hill Cemetery Jan 14, 2005 Greencastle, PA * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Miller-Nowersox Funeral Home 21. Signature of Funeral Service Licensee Vianth III 521 S. Washington St., Greencastle, PA 17225 23a. Part I, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediete Cause (Final disease or condition resulting in death) Onset and Death **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Onknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 22 No 223.No 1 Yes 25. Was case referred to medical examiner?

1 X Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To completely filled in by the funeral 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Alatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of penifier 60319 MO 01, 10, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Ave. Takoma Park, MD20912 30 HAMMER 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			Please	Type or Print in Blac			•	•	
			for State	State of Maryland /	Department of Certificate of			2005	011.60
			State Registrar 1. Decedent's Name (First, Middle, La.)	st)	Certificate of	Deain	2. Date of Deat	ng. No(⊶ U U J	3. Time of Death
	Physici		HARRIET PAG	_	DER		Month O I	Day Year 66 05	1125 11
	/Medic Examin		4a. Eacility Name (If not institution, give	street and number)		or Location of Death	1	4c. County of Dea	th
	Funeral Director		5. Social Security Number 6. S				8. Date of Birth (Month, Day,	Year). 9. Bir VI	thplace (State or Foreign BGINIA
	and and		Usual Residence of Decedent 10a. State 10b. County	, 10c. City, IQ	wn or Location				10d. Inside City Limits
	ne Maryl 8a-f sho	ector	MD Worce	ester S	HOCKto	\cap			1 ☐ Yes 2 ♠No
	ath with the Marylan s 23a or 28a-f show	Funeral Director	10e. Street and Number 2307 Ward	Rd.	10f. Zip Code	864		0g. Citizen of What C	ountry?
21215-0036	d within 72 hours after death with the Maryland Jiene. It than "neturel", or Items 23a or 28a-f show It e Mayleal Exandrat rout be indiffed at	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ♥ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (S uban, Mexican, Puert lo <i>Specify:</i>	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whi	te, etc.
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Mary	d 2 shu th and 7 is m treum		19a. Informant's Name/Relationship (Typo, Print) 15 / daughter 10	9b. Mailing Address (Stre	et and Number or Ru K +	ral Route Number.		Zip Code) 0 V/4 23352
ore,	ges 1 and of Health If item 27 or other tr		20a. Method of Disposition 1 12 Burial 2 ☐ Cremation 3 ☐	20b. Place	of Disposition (Name of tery, crematory or other p	nlace)	Date 2	20c. Location - City or	1 1 . 1
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Bal	permit. Departr Import. any inj		21. Signifure of Funeral Service Licer	1 fort	FOR FUNER		P.O. PO)	Ka78 Ten	peranceville
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68760	rtificate be ex ng physician a as the burial	edical	(d Renal	Failure				
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Ö.	at the de by the a tached	hysl	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown					
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eco	e law requir has been si je 2 should I	Completed					24a. Was ar	24b. Were a	utopsy findings available completion of cause of
al R							perform 1 Yes 2	ned? death?	
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n of	ng Phy Iter this	-	27. Manner of Death 1 ✓ Natural 5 ☐ Pending		. Time of 28c. In Injury		28d. Describe ho		Uny)
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Divi	tal or Attending P s after death. el Director: After ti ed in by the funera	Certif	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	rarm, street, factory, offic	Э	City or Town	reet and Number of R , State)	urai Houte Number,
	To the Hospital or Attending Pr within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	edical (29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exar	ysician: To the best of my knowled niner: On the basis of examination a and manner stated.	ge, death occurred at the and/or investigation, in my	time, date and place y opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as ate and place, and due	s stated. e to the cause(s)
	To the To the Comple	Me	29b. Signature and title of certifier		29c. Lice	nse number	29	d. Date signed (Mont	h, Day, Year)
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	10		30. Name and address of person who Babulal Da		(Type, Print)	504B,	Salisbur	m, MD.	21801
	Sta Regist		31. Date filed (Month, Day, Year) JAN 1 0	2005 Signature	* Sparke				

			For State Registrar	ate of Maryland	•	irtment of H			ene • 200	5 (1461	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) BARRY BUSC	HELL				2. Date of Death Month JANUARY	Day	Year 5	3. Time of Death 4:15A M	
)	Examir		4a. Facility Name (If not institution, give street POTOMAC VALLEY NURS			4b. City, Town, or POTO	4AC		4c. County of Death MONTGOMERY			
	Funeral Director		5. Social Security Number 102–28–7996 6. Sex 151 M 3	7. Age (In yrs. Ias 2□ F 71	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		^{Year)} 1933	9. Birthpla Country NEW	Ace (State or Foreign YORK	
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hydiene.	should be filed within 72 hours after death with the Maryland of Mental Hygiene marked other then "naturel", or items 23e or 28a-f show metic event, the Medical Examinat must be multibut at	Funeral Director	10a. State 10b. County MARYLAND MONTGOMER 10e. Street and Number 8803 LIBERTY LANE			OMAC 10f. Zip Code 208		UN	10d. Inside City Li 14 Yes 2 10g. Citizen of What Country? UNITED STATES OF AMER y Yes or No- 14. Race - American Indian,			
	iours after d urel', or item L'Examinar	by	1 Never Married 2 Married 1	med Forces? □¥es 2□No ARMY Yes, Give ear or Dates:KOREAN		Yes, specify Cuba	Specify:	Specify Yes or No- rto Rican, etc.)	Black	WHIT	tc.	
	ed within 72 h ygiene. ier then "natt t, the Medica	Completed		ollege (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done of DO NOT use retired	during most of wo	orking	FO	Sb. Kind of Business/Industry FOOD		
and	be d la la la la la la la la la la la la la	To Be	17. Father's Name (First, Middle, Last) HERMAN BUSCHE	LL				ame <i>(First, Middl</i> e, M IS GLASSM		.)		
	and 2 should ealth and Men n 27 is marke ier treumetic		19a. Informant's Name/Relationship (Туре, Р JOYCE R. BUSCHELL - V			_		OTOMAC, M			ode)	
Baltimore,	Pages 1 nent of Hu ant: # iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 1 ☐ Donation 5 ☐ Other (Specify)	(al from State Сеп	netery, cren	sition (Name of natory or other plac D MEMORIA		Date 2	0c. Location - 0		CHURCH, VA	
Balti	permit. Pages Department of Importent: If i eny injury or once.		21. Signature of Funeral Service Licensee	tottlemy	<u>ئ</u> 1			G MEMORIA				
Physician /Medical Examiner		Examiner	resulting in death)	CARDIOPULMON Due to (or as a conseque CURONARY ART Due to (or as a conseque	ARY Ance of):	RREST	g, such as cardia	ac or respiratory arre	st,	10	Approximate nterval Between Onset and Ceath	
.O. Box 68760,	at the death certificate be executed by the attending physician and tached for use as the buriat-transit	Physician/Medical Ex	d	yes, outcome of pregnanc Live birth 2 Fetal d Pregnant at time of dea	y eath 3□	Ectopic pregnancy			23d. Date Mont	of delivery	/ Vay Year	
rds, P	quires that n signed t uld be deta	by	CONCECUTIVE HEADY BATTING HOLD INDUDING TOOL DESCRIPTION								cause of death?	
Il Records,	: The law requires that the cate has been signed by th page 2 should be detache	Completed	SEVERE BIPOLAR DISORI	DER, ENTEROC	UTANE	OUS FISTU	JLA	24a. Was an autopsy perform 1 ☐ Yes 2	ed? de	ere autops for to comp eath? Yes 2	sy findings available pletion of cause of	
f Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospit	al: 1 Inpatient 2 EF	VOutpatien	t 3 DOA		eath <i>(Check only one</i> Home 5 Resider		r (Specify)		
Division of	Attending Ph death. ctor: After th y the funeral		1X Natural 5 ☐ Pending investigation	a. Date of Injury 2. (Month, Day Year)	8b. Time of Injury	28c. Injun Worl	/ at	28d. Describe how				
Ö	or / after Dire in b	Certification;	4 Homicide	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospitel within 24 hours of To the Funerel I completely filled	ledical	(Check only 2 Medical Examiner: (i: To the best of my knowled on the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time restigation, in my of	ne, date and plac pinion, death occ	e, and due to the car surred at the time, da	use(s) and man te and place, ar	ner as state nd due to th	ed. ne cause(s)	
ı	with com	Σ	29b. Signature and title of certifier	- Or		29c. License	60036		d. Date signed NUARY 4			
			30. Name and address of person who comple MAHMOUD DOSKI, M.D.,			Print)		RING, MD	20902	, 200	-	
b.	Sta Registi		31. Date filed (Month, Day, Year) JAN 06 2005	32. Figistrar's Signatur								

			=	State of Maryla	nd / Depa		lealth and M	lental Hyg	•	05	014	62	
	Physici /Medic		Decedent's Name (First, Middle, Last)	Burkett, Sr	•	-		2. Date of Deat Month January	h Day	Year 2005	3. Time of 0	Death A ^M	
	Examin		4a. Facility Name (If not institution, give str Sunrise Assisted			4b. City, Town, o Freder	r Location of Death		4c. County Fred	of Death	ξ.		
ı	Funeral Director		3//-03-3/00	7. Age (in yr. 89	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 14	Year) 1915	9. Birthpl Coun Virg	lace (State or try) ginia	Foreign	
death with the Maryland	show	or.	Usual Residence of Decedent 10a. State 10b. County Maryland Fredericl		City, Town or Lo					16	0d. Inside City		
	with the N s or 28e-1	Director	10e. Street and Number		Tedeli	10f. Zip Code		10	0g. Citizen of \	What Coun			
	s 23	ral	990 Waterford Driv		11.0	21702			Jnited				
2-0036	be filed within 72 hours after death with the Marylan lat Hygiene. Id other then "naturel", or liems 23a or 28e-f show event, the Medical Evaninar must be nutitied at	by Funeral	11. Marital Status 12 1 Never Married 2 Married 3 Microced 4 Divorced	. Was Decedent Ever in Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates:		f Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		ce - Americ ck, White, o Whi	etc.		
	within 72 hou ene. then "nature he Medical E	ompieted	15. Decedent's Educa (Specify only highest grade of	tion completed) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occup kind of work done OO NOT use retired	ation during most of work d)	ing	16b. Kind of B	usiness/Inc	lustry		
7	e filed within al Hygiene. I other then " vent, tre Me	Con		2	Farme	er			Self E	mploy	ed		
yland	be file	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name			1			
Va	2 should be and Mental is marked creumatic every	To.	Abram J. Burkett	s Clara									
, mar	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if item 27 is marked any injuryor other treumatic evones.		19a. Informant's Name/Relationship (Type Burge W. Burkett,	Jr. / Son	2256	Wilcoms		amsville	, Mary	1and	21754		
Baltimore,	Pages 1		20a. Method of Disposition 1 ☐ Burial 2 ⚠ Cremation 3 ☐ Rer `4 ☐ Donation 5 ☐ Other (Specify)	IIOTAI IIOIII State		sition <i>(Name of</i> natory or other plac tan Crema	Jan	. 3,	20c. Location - Alexand	-		nia	
Balt	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee	1~	22	. Name and Addre		Vol Fune		me			
			23a. Part1. Eller the cisease, or complica shock, or heart failure. List only one		ath. Do not ent	er the mode of dyin					Approximate Interval Betwo	een eath	
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Parkinson Due to (or as a conse		ase							
,00,	be executed ician and burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
200	ficate physis the		d.									175	
C. Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							23d. Date of delivery Month Day Year		
ras, P.	iw requires that t s been signed by should be detail	by	Part II. Other significant conditions contri Dementia	buting to death but not re	esulting in the ur	nderlying cause grv	en in Part I.		acco use cont s 2 X) No				
II Record	The law ate has b page 2 st	Completed						24a. Was ar autopsy perform 1 Yes 2	/ ₩ad?	prior to con death?	esy findings av		
VITal	icien: The certificate rector, pag	Be	25. Was case referred to medical examiner?	spital:		Oth	26. Place of Deatl	h (Check only one	9)		Assist	ed	
ō	Phys this al dii	ion; To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injun Wor	y at	me 5 Resider 28d. Describe hor		er (Specify	Living		
UIVISION	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	ertification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)			28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)			ar,	
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physic (Check only one)	ian: To the best of my kin: On the basis of examination of manner stated.	nowledge, death nation and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occurr	and due to the ca red at the time, da	use(s) and ma te and place,	inner as sta and due to	ated. the cause(s)		
	To th within To th compi	Me	29b. Signature and title of ceptifier	11 7	de.	29c. Licens		29	d. Date signed	d (Month, E	Day, Year)		
1	1011		Milly	THER	- M	$\mathcal{D} \mid \mathcal{D}$	35/8	53/	unua	my 3	,000	5	
	- 11		30. Name and address of person who com Ali Afrookteh, M.		эт 23a) (Туре, st 9th S	Print)	rederick,			()	~		
	Sta Registr		31. Date filed (Month, Day, Year) JAN 0 6 200	32. pegistrar's Sig	B A	outi							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** <u>12:</u>15^a [™] Carol J. Boyer January 4, 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🕱 F 12, 1927 Director 227-26-5825 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 shours be move......
Department of Health and Mental Hygiene.
Important: If item 27 la marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once. 10a. State 10b. County 1 ☐ Yes 2 No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9707 Old Georgetown Road 20814 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White Specify: 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Development Director Marketing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) A. I. Jackson Christina Elizabeth Wachsmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2505 Forest Glen Road, Silver Spring, MD 20910 Richard Sterling Mehring/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition January 9 1

Burial 2 □ Cremation 3 □ Removal from State Forest Lawn Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 2005 Norfolk, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc
500 University Blvd, W, Silver Spring, 21. Signature of Funeral Service Licensee Collec 23a. Part1. Enter the disease, or complications that cabeal the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Cancer /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit that initiated events signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 2 No 1 Yes 1 Yes or Attending Physician: the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 **X** No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 🛙 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D62347 January 5, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marjorie Dannis, M.D. 8600 Old Georgetown Road, Bethesda, MD 20718 Registrar's Signature 31. Date filed (Month, Day, Year, State JAN 06 2005 Registrar

			1 - State	e of Maryland / Dep		lealth and M	lental Hygi	_	5 01464			
H	Physicia	an	1. Decedent's Name (First, Middle, Last) Ann E. Brown		orimeate or i	<u> </u>	2. Date of Death Month January		3. Time of Death			
	/Medic	al	4a. Facility Name (If not institution, give street as	nd number)	4b City Town o	r Location of Death	January	4c. County o	- '			
	Examin	er	Lorean Nursing Cente:		Mount			Carro				
	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 25	7. Age (In yrs. last birthday			8. Date of Birth Month Day, May 11,		9. Birthplace (State or Foreign Country) Delaware			
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits			
	e-f sh	tor	Maryland Carroll	Mount	Airy				1√2 Yes 2 □ No			
	vith the	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wh	nat Country?			
	9ath v	Funeral	713 Midway - Apartme	ent 358 Decedent Ever in U.S. 13	2177 3. Was Decedent of H		ecify Yes or No-	U.S.A.	- American Indian,			
0	after d or Item olicer	Fun	Arm	ed Forces? Yes 2 ☑ No es, Give 🏠	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto Specify:	Rican, etc.)		, White, etc.			
3	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. I term 27 Is marked other than "neturel", or Items 23e or 28e-f show other treumetic event, ITE Marical Examiner must be multiled at	d by	3 Wildowed 4 Divorced Yea	r or Dates:	1 ☐ Yes 2 No		1		Specify: White			
5	n 72 t	Completed	15. Decedent's Education (Specify only highest grade compl	eted) 16a. Dec (Giv. life.	cedent's Usual Occup we kind of work done . DO NOT use retired	ation during most of work d)	ing 1	6b. Kind of Bus	6b. Kind of Business/Industry			
7 7	filed withi Hygiene. Ither ther	mo:	Elementary/Secondary (0-12) Coil	ege (1-4or5+)	gram Mana			U.S. Go	vernment			
2	oe filer al Hyg d othe	Bec	17. Father's Name (First, Middle, Last)	-		18. Mother's Nam	e (First, Middle, M	laiden Sumame)			
<u>X</u>	should be and Mental smarked o umetic eve	2	Edward T. Paxt		illing Address (Street	Evelyn	Badger	City or Tourn	tato Zin Codo)			
<u>0</u>	id 2 sho lth and 27 Is m		19a. Informant's Name/Relationship (Type, Prin						Maryland 21770			
Ď,	permit. Pages 1 and 2 Department of Health Importent: If item 27 eny injury or other tru once.		20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place				City or Town, State			
	Page		1 ☐ Burtal 24 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State			1/06/05	Alexand	ria, Virginia			
Dallillor	permit. Departi Import eny inj once.		21. Signature of Funeral Service Licensee		22. Name and Addre	ss of Facility						
	405 a a		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do not e	26401 Ridg	ge Road,	Damascu or respiratory arre	s, Mary	Approximate			
	Physician		shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	on each line. SEPTILEM					Interval Between Onset and Death			
	/Medical Examiner		regulting in death)	ue to (or as a consequence of):					0 11			
	Examine	<u>.</u>	Sequentially list conditions, b.	BREAST ue to (or as a consequence of):	CANCE	-1			9 months			
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<u>г</u> Э	at the	Phys	9 LI UNKNOWN				220 Did tob	acco use contril	oute to the cause of death?			
as,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by	Part II. Other significant conditions contributin	g to death but not resulting in the	underlying cause giv	en arranti.		_	3 ☐ Probably 4 ☐ Unknown			
Records,	w requ	ompleted					24a. Was ar		ere autopsy findings available			
	sicien: The law certificate has b irector, page 2 sl	omo					autopsy perform	ed? de	ior to completion of cause of eath? Yes 22 No			
Vital	ysicien: is certifica director, j	Be C	25. Was case referred to medical examiner?				th (Check only one	9)				
0	his his	-T	1 Yes 2 No Hospital 27. Manner of Death 28a.	1 Inpatient 2 ER/Outpati	ient 3 DOA		ome 5 Reside					
	ling After une	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	y Wor	rk? Yes 2□No						
UNISION		Certification:	action in a first could not be	Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (Str City or Town		r or Rural Route Number,			
2	To the Hospitel or within 24 hours after To the Funerel Discompletely filled in	Cer	29a. Certifier 1 Certifying Physician:	To the best of my knowledge, de	ath accurred at the ti	mo, dato and place	and due to the ca	uso(s) and man	iner ac etated			
	e Hos 24 hc e Fun letely	edical	(Check only 2 Medical Examiner: On	the basis of examination and/or d manner stated.								
	To th Withir To th compl	Me	29b. Signature and title of certifier		29c. Licens				(Month, Day, Year)			
,			the) inj		31912		1105	105			
(9)		30. Name and address of person who complete	4 OPOSCULATOU	IN PINE	FAZDER	ilu, m	D 21-	102			
	Sta		31. Date filed (Month, Gar. Near) 7 2005	32. Registrar's Signature	books.	- 501						
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			For State Registrar	State of	Maryla		artment <i>rtificate</i>		ealth and M D <i>eath</i>		giene Reg. No.	05	01465
	Physicia	an	1. Decedent's Name (First, Middle, Last)							2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al				n Frank			r Location of Death	Januar		2005 unty of Deat	12:40a M
	Examin	er	4a. Fecility Name (If not institution, give s Frederick Memoria				40. City,		derick		40.00	Frede	
	Funeral		5. Social Security Number 6. Sex			. last birthday)	If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ıy, Year)	9. Birt	hplace (State or Foreign
	Director	}	Usual Residence of Decedent	IM ZUF	88	Yrs.				March 1	18,191	6 Ma	aryland
	Lail yilailia Z IZ I J-0000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28e-f show raumatic event, the Musical Examinar must be notilised at		10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	e-fsh	ctor	Maryland Howard		Mt	Airy							1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number			•	10f. Zip	Code			10g. Citizer	of What Co	ountry?
	s 23a		2050 Long Corner Ro	oad 12. Was Dece	dont Ever in	119 121	Nac Decad		1771	ecify Ves or No		ed St	
_	fter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed For	ces? 2 □ No				spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)		Black, White	
	rai', o	þ	3 Widowed 4 Divorced	If Yes, Give Year or Da	tes: WW	II	1 ☐ Yes 2	M No	Specify:		Sp	ecify: Wh	nite
ה ה	natu	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)		(Give	dent's Usua kind of wor DO NOT us	k done c	furing most of work	in g	16b. Kind	of Business/	Industry
7	withir ene. than	dwc	Elementary/Secondary (0-12)	College (1-	-4or 5+)		er/Op		•		Auto	Sale	s
2	i Hygi other	a)	17. Father's Name (First, Middle, Last)			OWII	СГТОР		18. Mother's Name	e (First, Middle	1		
/lana	ould be Menta arked atic ev	To B											
Mar	2 sho		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
a) (a)	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mentai Hygiene. If the 21 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Modical Examinar must be notified at		Pat Schmidt /Daugh	ter	20b.	Place of Dispo	sition (Nam	e of		BOX 325 Date		tion - City or	aryland 2177 Town, State
DE L	permit. Pages 1 Depertment of H important: If ite any injury or otl		1 ☑Burial 2 ☐ Cremation 3 ☐ R 14 ☐ Donation 5 ☐ Other (Specify)	emoval from S		cemetery, crer			etery 1/7	/2005	Μ÷	\irv.	Maryland
бащтог	mit. I pertm portar y infu		21. Signature of Fun ral Service Licen	90	,110				s of Facility lesworth				
<u> </u>	9 E E B		Joile Of	Uky	in	2	6401	Kidg	e Road, l	Damascu	s, Mar	yland	20872
			23a. Part. Enter the disease, or complishock, or heart failure. List only or	cations that cane caus on ea	ach line.								Approximate Interval Between Onset and Death
- 1	Physician Medical		Immediate Cause (Final disease or condition resulting in death)	1			1c ,	PRO	STATE	CAN	Chn	_	3-4 GEARS
	Examiner			Due to (or as a conse	equence of):							
_	البسا	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	equence of):							
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	S									
8/60,	icate be executed physician and s the burial-transit	al E	rosalling in doubly base		or as a conse	equence or):							
ρα	fficate g phys	edical											
ŏ	leath certifi attending p	Physician/M	200. Was decadent program 11 I ive high 2 Fetal death 3 Fetanic programmy									Date of delivery	
מ ה	e death the atter	slcla	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	s 2 \ No \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \								Month	Day Year
Ţ.	w requires that the de been signed by the should be detached		Part II. Other significant conditions con	ntributing to de	ath but not re	esulting in the u	nderlying ca	ause give	en in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
ທົ	requires een signi hould be	d by								10	Yes 2 🖭	√o 3□Pr	obably 4 Unknown
ecord	taw req as beer 2 shou	ompleted								24a. Was		24b. Were au	utopsy findings available completion of cause of
ř	0 4 0	Com								auto perfo	ormed?	death?	2 No
VITAI	iician: Th certificate rector, pag	Be (25. Was case referred to medical examiner?	lo anital:				Oth	26. Place of Deat				
5	this ald	. To	1 ☐ Yes 2 ☐ No ☐ C			☐ ER/Outpatier 28b. Time o			er: 4 ☐ Nursing Ho	ome 5 Resi			cify)
0	nding I nth. :: After e funer	atlon	1 atural 5 Pending 2 Accident investigation	(Monti	of Injury h, Day Year)	Injury	М	8c. Injury Worl	k? Yes 2 □ No				
DIVISION	al or Attending F s after death. I Director: After d in by the funera	Certification:	3 Suicide 6 Could not be determined	28e. Place buildin	of Injury - At	home, farm, str	reet, factory	, office		28f. Location (City or To		lumber or Ru	ural Route Number,
בֿ	oltat o urs aft irat Di			1					//				
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami		asis of examin								
	To the within To the comple	Me	29b. Signature and title of certifier	700.			29c	. License	e number		29d. Date s	igned (Mont	h, Day, Year)
			> Melle			- MD		D26	499		Janua	ry 5,	2005
	'O, x,		30. Name and address of person who co							1 0:-			
	Sta	ato.	Ronald E. Miller M 31. Date filed (Month, Day, Year)	1	t Lwell egistrar's Sig		Mt.	Airy	, Marylar	nd 217	/1		
	Sta Registi		31. Date filed (Month Dax Year) 7 2	UUD	W. Jeer	150		D.					

			For State Registrar	State of Ma		d / Depa		of H	ealth a	and M		giene	005	01466
	Physici /Medi	al	1. Decedent's Name (First, Middle,				BI	awı	ner		2. Date of Dea Month Januari	Day 4 4	Year 200 5	
	Examir Funeral Director	er	213-60-7966	Bayview +	lection (In yrs. Ia	L Ceule est birthday) Yrs.	.0	balt	If Under Hours	e 24 Hrs. Min.	8. Date of Birt (Month, Pa June 18		9. Birt Fred	h hplace (State or Foreign unity) lerick, MD
	Maryland	tor	Usual Residence of Decedent	erick		Town or Lo			1,,,-					10d. Inside City Limits 1 X Yes 2 ☐ No
	th with the 23a or 28a ust be not	Funeral Director	10e. Street and Number 111 West "B" S	treet			10f. Zip (Code 2171	6			10g. Citizen	of What Co USA	ountry?
900	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28e-1 show may injury or other treumatic event, tra Madical Exertinar must be natified at once.	by	11. Marital Status 1 Never Married 2	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:			Was Decede If Yes, speci 1 \(\text{Yes} \) 2		spanic Origin, Mexican Specify:		cify Yes or No- Rican, etc.)		Bleck, Whit	nican Indian, e, etc. nite
21215-0036	s within 72 he piene. r than "natur ine Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12			16a. Dece (Give life.	dent's Usual kind of work DO NOT use tor of	k done d e retired)	luring mosi		1		of Business/	Industry Inswick
Maryland 2	rould be filed i Mental Hygin narked other natic event, I	To Be C	17. Father's Name (First, Middle, La Dennis Eugene	Brawner							(First, Middle, Marie			
	and 2 she ealth and m 27 ls m		Ruth A. Brawne		no. n	111 1	West '	'B''	Stree	t, B	Route Numberunswic	k, MD	217	16
Baltimore,	nit. Pages 1 artment of H ortent: If ite injury or oti		20a. Method of Disposition 1 8urial 2 □ Cremation 3 4 □ Donation 9 □ Other (Special Service Lieus)		l	ace of Dispo metery, crer vnsvil	le He	ight	s 1	1/8/2		Browns	on - City or sville	
Ba	permi Depar Impor		Barbara A. W			10	00 Pet	ers	ville	Roa	neral H	swick	, MD 2	21716 Approximate
T. STATE	Pnysician /Medical	87	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Superficient of the control of th		Sho	ck	or dyning	, 3001 40	our dide o	Tospiratory an	1031,		Interval Between Onset and Death 2 days
	Examiner	ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Acute Due to (or as a	M	y o (u	rhal	h	nfar	ction	Λ			4 days
8760,	cate be executed oblysician and the burial-transit	dical Examiner	c. Due to (or as a consequence of): d. Other Architecture.									3 days		
.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buttal-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal	death 3	Ectopic pre Other (spe					23d.	Date of deli Month	very Day Year
Records, P	w requires that the de been signed by the a should be detached f		Part II. Other significant condition	1.	not result		nderlying ca	use give 10ks		emia		ebacco use d		the cause of death?
	vician: The law r certificate has be rector, page 2 sh	Completed by	Parkinson's S	Disease, A	estr	rctiv	e Li	lve	Di	Sease	24a. Was a autop perfor 1 Yes		4b. Were au prior to death? 1 □ Yes	topsy findings available completion of cause of 2 No
Division of Vital	ing Phys	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day)		R/Outpatien 28b. Time of Injury		lc. Injury Work	r: 4 🗆 Nu	rsing Hon 2	(Check only or ne 5 ☐ Resid 8d. Describe h	ence 6 🗆		sify)
Divis	tal or Atters after de el Directo	Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Place of Injury building, etc.	- At hon (Specify)	ne, farm, str	eet, factory,	office		2	8f. Location (S City or Tow	treet and No n, State)	umber or Ru	ral Route Number,
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying 2 Medical Exone)	Physicien: To the best of reminer: On the basis of e and manner state	xaminatio	rledge, death on and/or inv	estigation, i	in my op	inion, deat	d place, a th occurre	nd due to the c d at the time, c	ause(s) and late and pla	manner as ce, and due	stated. to the cause(s)
	with Con	2	29b. Signature and title of certifier			4	/	License	A-	000				1. Day, Year) 4 2005
	(3)		30. Name and address of person with	Tompking	th (Item :	23a) (Type,	Print) HopKi	ins	Bau	view)	Medical	(Purter	449	o Existen Avan
	Sta Registi		31. Date filed (Month, Day, Year)	7 2005 32. Registrar	s Signatu	ire .	Grand.	, si	- 1		- HW.		Legal I	10-1

DASHIELL, DENWOOD MILLARD Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

an	-	1. Decedent's Name (First, Middle, Last,					2. Date of De Month		Year	3. Time of Death			
cal		Denwood Milla			45 O.S. T.	al anating of Doot	JAN.	6:45 A M					
er	1	4a. Facility Name (If not institution, give Salisbury Nursing		or	4b. City, Town, o	r Location of Deat Salisbu			county of Death				
		5. Social Security Number 6. Sec			If Under 1 Year	If Under 24 Hrs	-			place (State or Foreign			
	2		≰M 2□F 81	Yrs.	Months Days	Hours Min.	8. Date of By (Month, Ba Nov. 7	1923	8 Mar	yland			
To Be Completed by Funeral Director	\vdash	10a. State 10b. County	10c. City,	Town or Lo	ocation					10d. Inside City Limits			
	į	Maryland Wicomi	ico	Sali	sbury					1 ☐ Yes 2 KNo			
		10e. Street and Number			10f. Zip Code				en of What Cou	ntry?			
	3	607 Dennis Stre			2180				S.A				
	2	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	. 13.	Was Decedent of I If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)) 14	 Race - Americano Black, White, 				
		1 ☐ Never Married 2 € Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1943	13	1 ☐ Yes 2 🗷 No	Specify:		5	Specify: Bla	ack			
	3	15. Decedent's Edu		16a. Dece	dent's Usual Occup	ation		16b. Kind	d of Business/In				
	5	(Specify only highest grad	le completed)	(Give	kind of work done DO NOT use retire	durina most of wo	rking						
		Elementary/Secondary (0-12)	College (1-4or 5+) 5 +		Teache	r		No	one				
		17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden S	Sumame)				
	2	Solomon Dashie	11			Alice	Weato	n					
		19a. Informant's Name/Relationship (T)	er, City or	Town, State, Zij	o Code)								
	1	Esther Dashiell	(Wife)	607	Dennis	St.Sali							
		20a. Method of Disposition	Ce Ce	metery, cre	osition (Name of matory or other pla	ce)	Date 1/10/	20c. Loc	ation - City or T	own, State			
		1 Burial 2 □ Cremation 3 □ I 1 Donation 5 □ Other (Specify,		ingh:	ill Mem	Garden	1/12/05	Heb	ron, Mc	i			
		21. Signature of Funeral Service Licens		3	S Cewad Address	funera:	l Home						
	-	23a. Part1. Enter the sease, or comp shock, or heart silure. List only of	Stewart		321 West				21801	Approximate			
i Examiner	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence.	ence of):	olo 1	C Cere			ý	201-			
	ed	23b. Was decedent pregnant	23c. If yes, outcome of pregnar		□Ectopic pregnanc	v		2:	3d. Date of deliv	•			
	Physicianim	in the past 12 months? 1 Yes 2 No 9 Unknown	4□Pregnant at time of de 9□Unknown		Other (specify)	,			Month	Day Year			
		Part II. Other significant conditions of	ontributing to death but not resu	lting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?			
	d by						10	Yes 2]No 3∏Pro	bably 4 dunknow			
2 - 2 -	ompieted						24a. Was		24b. Were aut	opsy findings available ompletion of cause of			
	E							ormed?	prior to co death? 1 ☐ Yes	ompletion of cause of 2□ No			
(S	25. Was case referred to medical				26. Place of De	1 ☐ Yes	2 ₩NO one)	. 🗆 163				
	O	avaminar?	Hospital: 1 Inpatient 2 1	ER/Outpatie	ent 3 DOA Ot	hor	Home 5 ☐ Res		□Other (Speci	ify)			
	- 1	27. Manner of Death 1 Death 5 Pending	ry at irk?]Yes 2 □ No	28d. Describe									
	Certification:	2 Accident 3 Suicide 4 Homicide investigation City or Town, Street, factory, office building, etc. (Specify)							l Number or Rui	ral Route Number,			
	Medical C	29a. Certifier 1 Dertifying Ph (Check only 2 Medical Exemone)	ysician: To the best of my knowniner: On the basis of examinational and manner stated.	wledge, dea ion and/or i	ith occurred at the to	ime, date and plac opinion, death occ	ce, and due to the curred at the time	cause(s) and	and manner as place, and due	stated. to the cause(s)			
1	Me	29b. Signature and title of certifier	-11		29c. Licer	se number	_	29d. Date	signed (Month	, Day, Year)			
1		29b. Signature and title of certifier 29d. Date signed (Month											
,		028748 47/65											

			For State Registrar	State of Maryla	and / Dep	artment	of Health and No of Death	Mental Hy	giene	2005	014	68				
h	Physicia		1. Decedent's Name (First, Middle, La JO ANN N/M/N					2. Date of De Month	Day	Yeer 2,2005	3. Time of Deat 3:50P					
2	/Medic Examin		4e. Fecility Neme (If not institution, giv			4b. City, 1	Town, or Location of Death			County of Deeth						
	Examin	er	SOUTHERN MARYI		AL	CLI	NTON		PR	INCE G	EORGES					
1	Funeral Director		377-40-1303	7. Age (In yi	rs. last birthday, Yrs.	If Under Months	1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Bir (Month, Da MAR • 4	y, Year)	9. Birth <i>Co</i> u 6 ALA	plece (State or For intry) BAMA	eign				
5-00.50 72 hours after death with the Maryland "netural; or ttema 23s or 28s-f ahow	and I		Usuel Residence of Decedent 10a. State 10b. County	10c.	City, Town or L	ocation					10d. Inside City Lin	nits				
	Mary	ţ	MARYLAND CHAF	RLES	WALDO	RF					1 ☐ Yes 2 🎇	No				
	r 28.	Directo	10e. Street and Number			10f. Zip	Code		10g. Citiz	en of What Cou	intry?					
	th with	aiD	6342 PORCUPINE	COURT			0603			.S.A.						
	dear dear	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ② No If Yes, Give	I U.S. 13.	Was Deced	ent of Hispanic Origin? (S ify Cuban, Mexican, Puert	pecify Yes or No o Rican, etc.))- 1·	 Race - Amer Black, White 						
2 0	hours after tural', or Ite al Examine	ρ	1 ☐ Never Married 2 ☐ Married				ITE									
	n 72 h "netu	Completed	15. Decedent's E (Specify only highest gr	ade completed)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	I Occupation ik done during most of wor e retired)	king	16b. Kin	d of Business/li	ndustry					
7	within iene. than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)			IANAGER		sou	THERN	MD HOSP	ΙT				
0	other ent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle	, Maiden S	n Sumame)						
lar lar	uld be Aenta rked tic ev	To B	DARRELL F. WOO	LWINE			JEAN	Mc QUA	AID .							
a Z	s 1 and 2 shoul f Health and Mi Item 27 is mari other traumati		19a. Informant's Name/Relationship	Da. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or												
Σ 	and and and and and and and and and and		TAMMY PAYNE-DA				RCUPINE CT.	, WALDO								
o e	Pages 1 nent of H int: # Ites iny or oth		20a. Method of Disposition 1 Burial 2 Cremation 3	Hemoval from State	cemetery, cre					ation - City or T						
	5 5 5		*4 Donation 5 Other (Speci				IS CEM. 1-2	25-05	CHE	LTENHA	M,MD					
Baltimore,	Departiment Depart		21. Signature of Funeral Service Lice	nsee MU(RAYMO	d Address of Facility ND FUNERAI									
			23a. Part1. Enter the disease, or con	polications that a used the d			ATA, MARYI e of dying, such as cardiac		20646 rrest,	2	Approximate					
Phys	Physician	(I	shock, or heart failure. List only Immediate Cause (Final disease or condition	a. SEPS15							Interval Between Onset and Death	1				
	/Medical Examiner		resulting in death)	Due to (or as a cons							2 WEER	10				
	r.	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ACUTE Due to (or as a cons	BACTEA sequence of):	LIAL	PERMO	70 7 3 73	>		30 V-10 D 1	·				
20, -1	be executed sicien and burial-transit	Examlner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. STENO Due to (or as a cons		HOM	ONAS M	ALTO	PH1	LIA						
-	9 2 0	dical	•	d												
Box 68	ath certif attending for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etel death 3	□Ectopic pr		2	3d. Date of deliment	very Day Year						
д О	that the de led by the a detached	hys	9 Unknown	9□ Unknown	2000 1 1 2			12. 22. 22.		5 200						
Vital Records, F	200	by	Part II. Dther significant conditions CORDNARY F								the cause of death					
S	aw require s been si 2 should l	Completed	CEREBRAL	THRO	THROMBOSIS				an	24b. Were au	topsy findings avail	able				
ř	Physician: The lav this certificate has al director, page 2	EO	DIABETES ,	MELLITUS	REI	VAL	FAILURE	perfo	ormed?	death?	2 No					
<u>E</u>	ian: ntifica ctor, p	BeC	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only								
<u>></u>	hysic his ce I dire	Tof	1 Yes 2 No	Hospital: 1 Inpatient 2							cify)					
<u> </u>	ding P h. After t funera		27. Magner of Death 12 Natural 5 Pending	28a. Date of Injury (Month, Day Year	r) 28b. Time Injury	of 2	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe	how injury	occurred						
Division of	dead ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not determine	28f. Location (City or To	(Street and wn, State)	i Number or Ru	rai Route Number,									
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	Medical C		thysician: To the best of my iminer: On the basis of exam and manner stated.												
	To th To th COMP	Me	29b. Signature and title of certifier	1 -3	0	29	c. License number		29d. Date	signed (Month	n, Dey, Year)	,				
•			1 Pame	la ejuit	an	D	0016110		, , ,	ري ري	0057					
	6		30. Name and address of person who	completed base of death (A WAY R 23 Penintrare S	(Item 23a) (Type	Print) F	O CLINE	CONA	n.D	207.	35					
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Pegistrar's Si	ignature	Laste	,									

State of Maryland / Department of Health and Mental Hygien \cite{D} Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Wilburn tolder 01 05 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington W. N.a.ms.Jort

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. T. (Month, Day, Home wood 9. Birthplace (State or Foreign Country) Vest Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Director 233-16-4406 87 Yrs. West Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Smithsburg Maryland Washington Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22044 Mohawk Drive 21783 23a USA filed within 72 hours after death Funeral Hems 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ဩYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 Widowed 4 Divorced White WWII naturel Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if liem 27 is marked other then any Injury or other traumatic event, the Me gines. Elementary/Secondary (0-12) College (1-4or 5+) 12 Procurement Officer U. S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ira Wilburn Folden, Sr. Mary Elizabeth Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph A. Folden/son 9068 Dawn Court, Myersville, Maryland 21773 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Gap Veterans 1-21-2005 Flintstone, Maryland ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Furniral Service License 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home Myersville, MD 21773 23a. Part1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Phelimonia week /Medical Due to (or as a consequence of): Examiner years Dementia Sequentially list conditions, if any, leading to inflinediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of, Examine burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): Box 68760. signed by the attending physician d be detached for use as the buria Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Diabetes 1 ☐ Yes 2 ☐ No 3 🗍 Probably Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? (es 2500 certificate 2 No 1□ Yes 1 🗆 Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 2 ER/Outpatient 3□ DOA \$his After thi funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification; 1 Natural
2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 047234 16/05 Tours 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) 747 Northern Ave Ma 32. Egistrar's Signature 31. Date filed (Month, Day, Year) State JAN 2 1 2005 Registra

			1 - For State Registrar		partment of Health and Mertificate of Death	∕lental Hygie Reg.	4000	01470
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36	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or items 23a or 28a-1 show avent, tre Medical Exertire rusal tendified at	by Fu	1 Never Married 2 Married 1 1	es 2 ∏ No s. Give X	1 ☐ Yes 2 ☑ No Specify:	nican, etc.)	Black, White, et	
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0	al or A s after il Dire	Certification:	4 Homicide building, etc. (Specify)		City or Town, Sta	te)	
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	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. The Fundatal Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as:	ledical			it the time, date ar	nd place, and due t	to the cause(s)
	To To Con	Σ		cense number	29d. D.	ate signed (Month,	
				146561	JA	N. 17.	, 2005
	4		30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) GITMINA & ADIX 1190 M7 AETWA ROAT)	the	nad 3	g top J.	
	Sta	te	31. Date filed (Month, Day, Year) 32 Registrar's Signature	HARBATOWN	MD 2	1740	
	Registr						

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Yeer **Physician** Claudette H. Gibbs 2005 3:51P. Jan. 6, /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico 102 E. East St. Delmar If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🛣 F Director 215-38-2217 65 12-28-1939 Md. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f ahow the Medical Examiner must be notified at Director 1X Yes 2 No Md. Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 E. East St. 21875 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: t3. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Nursing Home Nurses Aide permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any linjury or other traumatic event 9068. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Julia Taylor Harrison Jones 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21875 Marvin Gibbs, Husband 102 E. East St. Delmar, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) St. Stephens Cem. 1-10-05 Delmar, De. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home Short 13 E. Grove St. Delmar, De. 19940 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-aliure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition LIVER DISEASE **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be IHRUM BOCTTO FENIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 HNO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PINEBLURF RD FOLA SHADE 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 0 2005

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 20c per fth 8839 1-21-05 vt.
State of Maryland Department of Health and Mental Hygiene 055

1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JANUARY 16 2005 6:05 Ам BETTY JUANITA HOUSEL /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY 18400 OAK TREE LANE FROSTBURG If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) AUG 1 1930 Birthplace (State or Foreign MARY LAND **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. Yrs. 74 Director 215 26 6380 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND ALLEGANY FROSTBURG 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18400 OAK TREE LANE 21532 U.S. Items 23g Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours affer c Department of Health and Mental Hygiene. If item 271s marked other then "naturel", or Item any injury or other treumatic execution. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2X No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 COOK RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ANNA PEARL BURDOCK JAMES CLARK 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLARENCE HOUSEL, JR. P. O. BOX 486, FROSTBURG, MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) JOHNSON CEMETERY 1/19/05 Frostburg, Md. 21. Signature / Funeral Service Licensee 22. Name and Address of Facility 60 W. MAIN ST. pnce Dexu(+ SOWERS FUNERAL HOME, P.A. FROSTBURG, MD 21532 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARCINOMA **Physician** Lucka disease or condition resulting in death) merasiosis /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to jor as a consequence of Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached f Records, P.O. the 9 Unknown 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate has 1 Yes 1 Yes 2 No 2 No Division of Vital Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No this 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After To the Hospitel or Attending 1 Matural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of cectifier 29c. License number 29d. Date signed (Month, Day, Year) epelop no in -13166 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 48 Tanh Corrace trosimuna Mo Reout 31. Date filed (Month, Day,) ANGEL 32. Regis Signature

5 Marce & Speeds Registrar

State

Registrar

31. Date filed (Month, Day, Year)

JAN 2

2005

32. Paistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 14, 2005 **Physician** Goldie Malinda Hildebrand 12:32 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Northampton Manor Nursing Home Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Petition | 1991 | 2 7. Age (In yrs. last birthday) 92 Yrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Mary Land **Funeral** 1 □ M 2 🔀 F Director 212-14-7679 Usual Residence of Decedent with the Maryland 10b. Count 10a. State 10c. City, Town or Location in than "natural", or items 23e or 28e-f ehow the Medical Examinar must be notified at 10d. Inside City Limits Frederick Frederick Maryland Director N Yes 2 No 10g. Citizen of What Country? U.S.A. 10f. Zip Code 10e. Street and Number 200 East 16th Street 21701 death v Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. e filed within 72 hours after il Hygiene. other than "natural", or Ite 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Itam 27 Ie marked other tt any injury or other traumatic event, Ita once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles H. Summers Bertha Florence Hooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6133-K Springwater Place, Frederick, MD 21701 19a. Informant's Name/Relationship (Type, Print) Virginia Lee Bowser/Daughter Method of Disposition

Was Burial 2 Cremation 3 Removal from State Mt. **COTTO CENTRAL CONTROL (Name of Control Contro Jan. 17, 2005 20c. Location - City or Town, State Frederick, MD 21701 20a. Method of Disposition ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Keeney & Bastord Funeral Home M00021 106 East Church Street, Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that drused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ALZEIMERS DEMENTIA 4 EARS /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertaing Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last The law requires that the death certificate be execu Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 □ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 24 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 2 1 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Hursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) After thi 27 Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year) 026499 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller, M.D., 4 Culwell Drive, Mount Airy, Maryland 21771 31. Date filed (Month, Day Year) 32. egistrar's Signature State 2005 Registrar

State of Maryland / Department of Health and Mental Hygien® 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 12:43 PM William W. Hodges, Sr. Jan /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HEOMICO Medical REGIONAL PONINSULA 6. Sex 1-∑ M 2 ☐ F 8. Date of Birth (Month, Day, Year) 8-6-1929 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Days Min Md. 218-16-8198 75 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Salisbury Director Md. Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 Apt. C212 1514 Riverside Dr. filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Biscuit Co. Salesman permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othuany injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Florence Niblett Hodges John Hodges, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annapolis, Md. 21403 1238 Youngs Farm Rd. William W. Hodges, Jr., Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory Of Delmarva 1-12-05 Delmar, De. ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Short Funeral Home 21. Signature of Funeral Service Licensee 13 E. Grove St. Delmar, De. 19940 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiamyopathy Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the attending physician and ned for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant al time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, page 2 should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 🗆 No 1 Tyes 2 T No 25. Was case referred to medical Be 26. Place of Death (Check only one. examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 9 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital or 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Ind addre... 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRMC MO strar's Signature 31. Date filed (Month State 0 2005 Registrar

DHMH 17 Rev 1/2001

William Hodges

	1 - For State Registrar		/ Department of Health and Certificate of Death	Reg. N	. 1
an	Decedent's Name (First, Middle, Last	0			ay Year
	Elsie Watson 4a. Facility Name (If not institution, give	Jackson street and number)	4b. City, Town, or Location of Dea	January 7	2005 2:30 AM
	Atria Assisted Liv	ing	Salisbury If Under 1 Year Hours Min	1	Wicomico
	5. Social Security Number 6. Se	7. Age (In yrs. las		8. Date of Birth (Month, Day, Yea	9. Birthplace (State or For Country)
	Usual Residence of Decedent	92	Yrs.	September 1,	
	10a. State 10b. County	10c. City,	Town or Location		10d. Inside City Lin
ō					1 ∑ Yes 2 □
Director	Maryland Wicomic 10e. Street and Number	o Salis	10f. Zip Code	10a. C	Citizen of What Country?
	7770 - 7.1				
Funeral	1110 Healthway Dri	Was Decedent Ever in U.S.	21804 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	14. Race - American Indian,
Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ZNo	If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	Black, White, etc.
by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 No Specify:		Specify: White
Completed	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of w	orkina 16b.	Kind of Business/Industry
hdu	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of w life. DO NOT use retired)		
Ö	12	2	Homemaker		Domestic
Be	17. Father's Name (First, Middle, Last)			ame (First, Middle, Maide	en Sumame)
^o L	George David Wats		Elizak		Clayville
	19a. Informant's Name/Relationship (T	1	19b. Mailing Address (Street and Number or F		
	Carolyn Jackson El	more (daughter)	4200 Union Church Roa		
	20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ I		ce of Disposition (Name of netery, crematory or other place)	Date 20c.	Location - City or Town, State
	`4 □Donation 5 □Other (Specify,	Mount	: Hope Cemetery Janu	ary 11, 2005 As	aton, Pennsylvania
	21. Signature of Funeral Service Licens		22. Name and Address of Facility	Profossional	Accoienties
		truncy (FSF	Holloway Funeral Home 501 Snow Hill Roa	d, Salisbur	y Maryland 2180
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death, one cause on each line.	Do not enter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between
	Immediate Cause (Final disease or condition	ALZIEME	7 2 1 1		Onset and Death
	resulting in death)	Due to (or as a consequen			
	Cognestia by liet conditions	b			
ner	if any, leading to immediate	Due to (or as a consequen	nce of):		
Examiner	that initiated events	c			
	resulting in death) Last	Due to (or as a conseque	nce of):		
Ilcai		d			
Physician/Med	IF FEMALE:				
an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal do			23d. Date of delivery
SIC	1 ☐ Yes 2 ☐ No	4☐Pregnant at time of deal 9☐Unknown	th 5 Other (specify)		Month Day Year
Phy	9 Unknown				
by		ontributing to death but not resulting Thrive	ng in the underlying cause given in Part I.		use contribute to the cause of death
ted	· curyof	0 10/1/14		1 🗆 Yes	2 No 3 Probably
Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause
ρÖ				performed?	death?
Be (25. Was case referred to medical examiner?		26. Place of De	eath (Check only one)	
2	1 ☐ Yes 1 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	Nursing 3 DOA Other: 4 Nursing	Home 5 ☐ Residence	6 Other (Specify) 455 151 5
atlon:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury 2 (Month, Day Year)	8b. Time of 28c. Injury at Work?	28d. Describe how in	jury occurred
≓	2 ☐ Accident investigation		M 1 Yes 2 No		
(0	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Street and City or Town, Sta	and Number or Rural Route Number,
tifica		January, otor (opposity)		0.1, 0.1, 0.10	
Certifica		ysicien: To the best of my knowle	edge, death occurred at the time, date and place n and/or investigation, in my opinion, death occ	e, and due to the cause	(s) and manner as stated.
Certific	29a. Certifier 1 Certifying Phy	and manner stated.	n artwor investigation, in my opinion, death occ	curred at the time, date a	nd place, and due to the cause(s)
Certific	29a. Certifier (Check only one) 2 Medical Exam		OOs Hassas sumber	29d. D	ate signed (Month, Day, Year)
Medical Certifica	(Check only 2 Medical Examone) 29b. Signature and title of certifier		29c. License number		1 " -
Certific	29b. Signature and title of certifier	ovulse o	MD D34014	1,	110/05
Certific	29b. Signature and title of certifier		MD D34014	1,	110/05
Certific	29b. Signature and title of certifier		MD D34014	1,	and lisoy.

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Ľ	For State Registrar	State of Mary		artment of H			giene Reg. No	005	01479
П	Dhysisi		1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	ath Day	Yeer	3. Time of Death
	Physicia /Medic		BERNARD REEL	KAUFFMAN				JANUAR		2005	8:35PM
	Examin	ĕr	4a. Facility Name (If not institution, giv			4b. City, Town, or		eath	4c. Co	ounty of Death	
			TALBOT HOSPICE F 5. Social Security Number 6. S		ura lant hirthdaul	EAS'		re 0 B (B)		TAL	
	Funeral Director		220-01-0332		yrs. last birthday) }6	Months Days	Hours Mi		Year)	8 MA	olace (State or Foreign RYLAND
-			Usual Residence of Decedent							0 123	TE ELLE
	rylan thow		10a. State 10b. County	100	c. City, Town or Lo	ocation					10d. Inside City Limits
:	8a-1s	cto		JBOT		EASTON					1√Yes 2□No
3	or 2	Dire	10e. Street and Number			10f. Zip Code			10g. Cîtizer	n of What Cou	ntry?
	eath v	eral	208 WILLIS AVE.	12. Was Decedent Ever	in II 9		601	(Specify Yes or No		USA Race - Ameri	one Indian
	riter d	Funeral Director	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ No	10.0.	If Yes, specify Cuba	in, Mexican, Pu	erto Rican, etc.)	,- 14.	Black, White,	
3	ral', o	by	3 ☐ Widowed 4 ☐ Vivorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Sp	pecify: WI	HITE
5	be filed within 7/2 hours atter death with the Maryland tal Hygiene. Ital Hygiene. d other than "netural", or items 23e or 28a-f show event, it with a first intermited the notified at	Completed	15. Decedent's En (Specify only highest gra	ducation ade completed)	(Give	dent's Usual Occup	during most of w	vorking	16b. Kind	of Business/In	dustry
7	Mithin 900.	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired		MODE			
7	Hygie ther t		17. Father's Name (First, Middle, Last		GRUCI	ERY & HARI		TURE lame (First, Middle,		ETAIL	
	buid be filed with Mental Hygiene. arked other that atic event, the h	To Be	GEORGE KAUFFMAN					BROWN		,,,,,,,,,	
2	2 should and Mer Is marke eumatic	-	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a		Rural Route Number	er, City or To	own, State, Zij	Code)
ž .	s 1 and 2 should be lined within 72 hours atter death with the Maylan ferbeath and Mental Hygiene. If Health and Mental Hygiene. If the 21 is marked other than "netural", or liems 23e or 28a-f show other treumatic event, If a Marchal Examiner must be notified at		DORIS MOTOVIDLAK/	DAUGHTER	2147	2 WHARF I	RD., TI	LGHMAN, M	D 216	71	
. ע	of He of He or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		Ob. Place of Dispo cemetery, crea	osition (Name of matory or other place	:e)	Date	20c. Locat	tion - City or To	own, State
	Pages tment of the tent: If its jury or o		*4 ☐ Donation 5 ☐ Other (Specif	(y)	SPRING H	HILL CEME	TERY 1-	-15-2005	EAS'	TON, MA	RYLAND
ם ח	permit. Pages 1 and 2 Department of Health a Importent: If item 27 it any injury or other tre		21. Signature of Funeral Service Licer			2. Name and Addres	ss of Facility HELFENB	ST ⁿ e&sT6N	NAM F	UNERAL.	HOME PA
	40244		23a. Part1. Enter the disease, or com							21601	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	1 1 4			carcu			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a co		00031	a C	car ca	COPV	-9	LVR
	Examiner		Sequentially list conditions.	b							
_	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of):						
	and al-tran	хап	that initiated events resulting in death) Last	cDue to (or as a cor	nsequence of):						
0	cate be executed physician and the burial-transit	dlcal E	l	d							
		ledk		U							
2	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		Ectopic pregnancy			230	I. Date of delive	•
5	The law fequires that the death certinities that been signed by the attending tage 2 should be detached for use as	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown	4☐Pregnant at time 9☐ Unknown		Other (specify)				Month	Day Year
	d by fetach		Part II. Other significent conditions	Contabuting to death but no	t reculting in the u	ndoshina anusa anu	on in Dert I	220 Did t	obacco uso	contabuto to t	he cause of death?
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cords,	v requ been shoul	ete						-			
ב ב	sicten: The law s certificate has b lirector, page 2 s	ompleted		46.484				24a. Was autor perfo			psy findings available mpletion of cause of
		e Cc	25. Was case referred to medical				26 Plane of D	1 ☐ Yes Death (Check only o	2000	1 🗆 Yes	2 No
>	Physicien: The hysicien contilicate har director, page	To B	examiner? 1 Yes 2	Hospital:	2 ER/Outpatier	nt 3 DOA Othe	or	Home 5 Resid		Sther (Specif	HOSPICE
5			27. Manner of Death 1 Chatural 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	f 28c. Injun Worl		28d. Describe I			HOUSE
200	tending death. tor: Alter the funer	catle	2 Accident investigatio				Yes 2 □ No				
2	or At offer d Direct in by	Certification;	3 Suicide 6 Could not be determined		At home, farm, str pecify)	reet, factory, office		28f. Location (S City or Tox		lumber or Rura	al Route Number,
-	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.		29a, Certifier 1 Certifying Pr	nysician: To the best of my	knowledge deat	h occurred at the tim	ne date and nia	uce, and due to the	Causa(s) an	d manner as s	tated
	ne Hoo	edical	(Check only 2 Medical Exer	miner: On the basis of exa and manner stated.	mination and/or in	vestigation, in my of	pinion, death oc	curred at the time,	date and pla	ace, and due to	the cause(s)
	within comp	¥	29b. Signature and the o certifier	MAR		29c. License	number	m /	29d. Date s	igned (Month,	Day, Year)
			1 / all he	ulle.	m()	1)	35 20	84	1[11	105	
			1//								
			30. Name and address of person who	completed cause of death	7 10 (Type,	Print) (1)ash	uneto	nSF 1	Fast	on M	021601
	Sta	to	30. Namula address of person who AMDIBA AU 31. Date filed (Month, Day, Year)	completed cause of death		8. Was h	ungto	nste	East	en M	021601

		Registrar				Ce	rtificat	e or i	Death			Rag. N	lo.		01480
ysicia	2	1. Decedent's Name (First, Mide	dle, Last)								2. Date of Do		ay	Year	3. Time of Death
ysicia. Nedica		HELEN	Α.	KLE	IN						JANUARY				4:45 A
amine	er	4a. Facility Name (If not instituti	. , 3				4b. City,	Town, or	Location (of Death		4	c. County	of Death	
		CLIFTON WOODS 5. Social Security Number	ASSIS 6. Sex			to a h h to to to to	-		SPRI				MONTO		
eral ctor		579-36-2636		M 2.√F	7. Age (In yrs. 74	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D AUG 5	nn ay, Yea 19	30	9. Birth	place (State or Forei intry) YORK
		Usual Residence of Decedent									AUG J	1 2	30	TATEM	TORK
18 78		10a. State 10b. Count	ty		10c. Ci	ity, Town or Lo	ocation								10d. Inside City Limit
Examinar must be notified at	Director		GOMER	RY		KENSIN	IGTON								1 X Yes 2 □ N
200		10e. Street and Number					10f. Zip					10g. C	Citizen of W	/hat Cou	intry?
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	Funeral	1 Never Married 2 Ma		Armed Fo	rces?	7.3.	If Yes, spec	city Cuba	in, Mexicar	, Puerto	ecify Yes or No Rican, etc.)	D-		k, White,	ican Indian, , etc.
	کر ا	3 Widowed 4 Divorce	1	If Yes, Giv Year or Da	/8		1 Yes	2 X I No	Specify:				Specify:		WHITE
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	Be	17. Father's Name (First, Middle HARRY		TD ED C							(First, Middle			•	
ŀ	ို	19a. Informant's Name/Relation		BERG		10h Maili	na Addrasa	/Ctract o		FANN.			OCKNI		0.43
		HENRY J. KLEIN		SBAND							I Route Numb				o Code)
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	1	For State Registrar	Cidio	J. 11101	y control / L	-	tment of H <i>ficate of l</i>				Reg. No.	005	0148
	_	1. Decedent's Name (First, Middle,	, Last)							2. Date of De Month	ath Day	Year	3. Time of Death
Physiciar /Medica	_	Faith	Keeney							Januar	y 4,	2005	8:44 a
Examine		4a. Facility Name (If not institution,	give street and r	number)		4	b. City, Town, or		of Death			County of Dea	
		Suburban Ho	-	7 400	(In yrs. last bii	irth doul	Betheso	da If Under:	24 Hrs. T	8. Date of Bir		Montgo	nery thplace (State or Fore
Funeral Director		5. Social Security Number 094-30-1810	6. Sex 1 ☐ M 2 🔀 F		67		Months Days	Hours	Min.	(Month, Da August 2	v. Year)	C	w York
	ļ.,	Usual Residence of Decedent											
thow		10a. State 10b. County		1	10c. City, Tow								10d. Inside City Lim 1 ☐ Yes 2 🛣
ene. then "natural; or Items 23e or 28e-f show the Modical Examinar must be notified at	ا پن		tgomery		Rock	ville					40. 000		
or 2		10e. Street and Number					10f. Zip Code	•			-	zen of What C	ountry?
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ltem Ingri	Lun	11. Marital Status 1 □ Never Married 2 □ Marrie	Amed	Forces?			is Decedent of H es, specify Cuba			Rican, etc.)		Black, Whi	te, etc.
P. P. P. P. P. P. P. P. P. P. P. P. P. P	<u>م</u>	3 Widowed 4 Divorced	If Yes,	Give r Dates:		1	Yes 21€ No	Specify:				Specify: Wh:	rce
ital Hygiene. dother then "natural", or Items 23e or 28e-f show event, the Medical Examiner must be notified at	Completed	15. Decedent (Specify only highes	's Education	d)	16a	. Deceden (Give kin	nt's Usual Occup and of work done of NOT use retired	ation during mos.	t of workir	ng	16b. Kir	nd of Business	/Industry
hen *	du l	Elementary/Secondary (0-12)		e (1-4or 5+))								
and Mental Hygiene. Is marked other then sumatic event, the Ma		17. Father's Name (First, Middle, I	(ast)	2		кеат	Estate			(First, Middle		eal Es [.] Sumame)	cate
ed of	o Be	Henry Keeney								Adams		·	
mark	ř	19a. Informant's Name/Relationsh	nip (Type, Print)		198	b. Mailing	Address (Street	and Numbe	er or Rura	l Route Numb	er, City o	Town, State,	Zip Code)
Ith ar		John B. Sadtl	or Jr	/ H116	sband	1050	O Rocky	ille :	Pike.	#1206	RO.	ckville	e, MD_2085
f Hea item othe		20a. Method of Disposition	<u> </u>			TOOO							
0		•		•	20b. Place o	of Dispositi	ion (Name of		D	ate _		cation - City or	Town, State
# # 5/2		1 ☐ Burial 2X☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		•	20b. Place o	of Dispositi ery, cremat		e)		y 7,	20c. Lo	cation - City or	Town, State , Virginia
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State

Registrar

JAN 0 6 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Oregory Kun Kunian, Willo Exercisive Blud, Surk 155, Rockville, Maryland 20852

31. Date filed (Month, Day, Year)

32 Registrar's Signature

			1 - For State Registrar	State of	Maryland / Depa <i>Ce</i>	artment of Hertificate of L			ene 005	01482
	Dharia		1. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month		3. Time of Death
	Physici /Media		James Lacy					January	1, 2005	3:40 p M
	Examir	er	4a. Facility Name (If not institution, g		er)	4b. City, Town, or		th	4c. County of Deat	h
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	Funeral Director		095.34.0676	Sex 1X M 2□ F	Age (In yrs. last birthday) 61 Yrs.	Months Days	Hours Min			hplace (State or Foreign untry) York
	and w		Usual Residence of Decedent 10a. State 10b. County	·	10c. City, Town or Lo	peation				10d. Inside City Limits
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	ems (Funeral Director	11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	panic Origin? (S	Specify Yes or No-	14. Race - Ame	
21215-0036	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may not you other traumatic event, the Modical Examitive must be routilled at once.	þ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 If Yes, Give Year or Date	∑ No	1 ☐ Yes 2 ☐XNo	Specify:	to Aican, etc.)	Black, White	White
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3	1 Mer narke	2	Archibald	-				Mary Train		
Maryland	d 2 sl th and 7 ls r traur		19a. Informant's Name/Relationship Robin Sherman/					ural Route Number, (nevy Chase	City or Town, State, 2	
ē,	Heal Heal tem 2		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	1	-	oc. Location - City or	
altimore,	ages ent of		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		ate cemetery, crei	natory or other place	1		lexandria	
ij	mit Poortan	i	21. Signature of Funeral Servine Lice	• • • • • • • • • • • • • • • • • • • •	/ 22	. Name and Address	of Facility	loseph Gaw	ler's Sons	VA The
ä			A State	mKor	5	130 Wiscon	sin Ave	enue NW WD	C 20016	, inc.
r			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that cau	sed the death. Do not ent	er the mode of dying	such as cardia	c or respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		atic Non Sma	all Cell I	ung Can	icer		Onset and Death
Н	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):					
ь		_	Sequentially list conditions,	b. Don't for	as a consequence of).					
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	Dus to (61	as a consequence on.					
Ć.	exection and ial-tra	Exa	that initiated events resulting in death) Last	c. Due to (or	as a consequence of):					
8760,	icate be executed physician and s the burial-transit	dicai		d						
9		Medi	IF FEMALE:		_					
Вох	eath certific attending p	an/h	23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth		Ectopic pregnancy			23d. Date of deli	-,
o.	the all	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□ Unknow	t at time of death 5	Other (specify)			Month	Day Year
<u>α</u>	that the de led by the a detached t	Phy	Part II. Other significant conditions	contributing to deat	h but not resulting in the u	oderlying cause giver	in Part I	23e Did toha	cco use contribute to	the cause of death?
Records,	es ped be	d by	•			loonying oxoso give	illi atti.			bably 4 \(\text{Unknown}\)
COL	w requir been s should	ete						24a. Was an	245 14/222 211	and the diameter will be be
Re	The lay	Completed			-			autopsy performe	prior to c death?	opsy findings available ompletion of cause of
Vital		0	25. Was case referred to medical				26 Place of Dec	1 ☐ Yes 2 ☐ atin Check only one)	∛No 1 ☐ Yes	2 □ No
\geq	d is	OB	examiner? 1 ☐ Yes 2 ሺ No	Hospital:	atient 2 ER/Outpatien	Othor			ce 6 □Other (Spec	fv)
n of	ding Ph h. After th funeral	n: T	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of I	njury 28b. Time of Injury	28c. Injury a Work?	at	28d. Describe how		.,,,
Sio	Attending r death. ector: After by the fune	catic	2 Accident investigation	n			s 2 No			
Division	- 0 -	Certification:	3 Suicide 6 Could not l 4 Homicide determined	289. Place of	Injury - At home, farm, streetc. (Specify)	eet, factory, office		28f. Location (Stree City or Town,	et and Number or Rui State)	al Route Number,
_	spital		29a. Certifier 1X Certifying P	hysician: To the be	st of my knowledge, death	Occurred at the time	date and place	and due to the caus	so(s) and manner as	rtated
	To the Hospital or within 24 hours affer the Funeral Dirticompletely filled in	edical	(Check only 2 Medica! Exa	miner: On the basis and manner	s of examination and/or inv	estigation, in my opin	nion, death occu	urred at the time, date	and place, and due	o the cause(s)
	To the Hospital o within 24 hours aft To the Funeral Di completely filled in	W	29b. Signature and title of certifier	2+1	0 -44	29c. License	number	29d	. Date signed (Month	Day, Year)
	- 1		Nand of	Minger	in - Mane	luy DIT	207	.I.	nuary 5,	2005
0.00	V		30. Name and address of person who			Print)				
			David S. Ettii 31. Date filed (Month, Day, Year)		• 900 Wolff strar's Signature	e Street	Baltimo:	re, Maryla	ind	
	Sta Registr			2005	we of Ap	sele?				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Charles Frank Mitchell, Jr. JANUANY 2005 4a. Facility Name (If not institution, give street and number) 4c. County of Death REGIONAL 5AL1364M Alcomico If Under 1 Year If Under 24 Hrs.
Months Days Hous Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1**₽**M 2□F 76 Yrs. 24 28 New York 10b. County 10c. City, Town or Location Accomack Onancock 10f. Zip Code

YONINSAUA Social Security Number **Funeral** Birthplace (State or Foreign Country) Director 088-22-7672 Usual Residence of Decedent 10a. State s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f ahow other traumatic event. The Medical Examinat must be notified at 10d. Inside City Limits Director 1 Yes 2 No Virginia 10e. Street and Number 10g. Citizen of What Country? Funeral 60 Kerr St. 23417 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 □X/es 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired)
 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Mechanic Foreman Poultry Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Suma 2 Charles Frank Mitchell, Sr. <u>Alberta Weishan</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Batta Mitchell/spouse 60 Kerr St. Ula 20b. Place of Disposition (Name of cemetery, crematory or other place) t of Health a 60 Kerr St. Onancock, Va 23417 Baltimore. 20c. Location - City or Town, State Pages 1 ö permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Jan. 7,05 Salisbury, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Williams Funeral Home the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or near failure. List only one cause on each line. 23417 23a. Part Approximate Interval Between Onset and Death Immediate Cause (Final diseas or condition resulting in death) Physician MHTRAL VAVE SIZERY 403125 /Medical Due to (or as a consequence of): Examiner UEBS REGULETTUNE b. MITEM VALVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The faw requires that the death certificate be executed years CALDIDAYOPATH DIGHTED Due to (or as a consequence of): Box 68760 attending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 Yes 2□ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Tyes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records. or Attanding Physician: Diractor: After the in by the funeral death. within 24 hours a

Physician /Medical

Examiner

Mitchell

Charles

1

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of cert

ical

C, 1000 MI) 31. Date filed (Month, Day, Year) JAN 1 0 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. Carrou ST. 32. R strar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

53551

SALISBURY Md

29d. Date signed (Month, Day, Year)

Physici		State Registrar Decedent's Name (First, Middle, Las	st)	Certifica	ate of Death	Reg. 2. Pate of Death	CUU DON	3. Time of Death
		RUTI		INEZ		Month	0ay 2005	7:00Am
/Medic Examin		4a. Facility Name (If not institution, give			y, Town, or Location of De	ath	4c. County of Deat	h
		DOCTORS COMMUN			LANHAM		PRINCE G	
Funeral		5. Social Security Number 6. S	□M 2 V } E	last birthday) If Und Yrs. Month	der 1 Year If Under 24 H s Days Hours Mi	n. (Month, Day, Ye	ar) 9. Birt	hplace (State or Foreign buntry)
Director		492-24-0166 Usual Residence of Decedent	81			JULY 29,	1923 MI	SSOURI
ahow		10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
ortant: If tem 27 is marked other than "natural", or Itams 23s or 28s-1 show injury or other traumatic event, the Medical Exament intuit be notified at s.	Director	MD. PRINCE O	GEORGES	R	IVERDALE			1 XYes 2 □ No
or 28	Dire	10e. Street and Number		10f. :	Zip Code	10g.	Citizen of What Co	untry?
s 238	irai	5204 WILEY S	12. Was Decedent Ever in U	S 13 Wee Do	20737	/Consider Van en No	U.S.	
fraction of the second	Funeral	11. Marital Status 1 ☐ Never Married 2 ▼ Married	Armed Forces?	If Yes, s	cedent of Hispanic Origin? pecify Cuban, Mexican, Pu	erto Rican, etc.)	Black, White	
Exam	by	3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 🗆 Yes	2 No Specify:		Specify:	HITE
dicul	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. Decedent's U	sual Occupation work done during most of w	yorkina 16b	. Kind of Business/	
A Ma	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired)			
H.		17. Father's Name (First, Middle, Last)	5+	НОТ	SEWIFE	lame (First, Middle, Maid	HOME	
C eva) Be	UNKNOWN	ASHER		10. (4)0(1)01 3 14	UNKNOWN	zen Sumame)	
ımati	2	19a. Informant's Name/Relationship (19b. Mailing Addre	ess (Street and Number or		ty or Town, State, 2	Zip Code)
r traum		JOSEPH A. MARTIN	NEZ/HUSBAND	5204 WI	LEY ST., RIV	ERDALE. MD.	20737	
othe		20a. Method of Disposition	20b. F	Place of Disposition (fi	lame of		. Location - City or	Town, State
3 0		1 ☐ Burial 2 ★Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		REMATORY 1-6	-2005 F	RIVERDALE	, MD.
any injury or other once.		21. Signature of Funeral Service Liger	isee /	22. Name	and Address of Facility ERS FUNERAL	HOME & CDEM	(ATODTIM 1	D A
2 9		M.M. Chai	nceue MOO	091 5801	CLEVELAND AV	E., RIVERDA	LE, MD.2	0737
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.			iac or respiratory arrest,		Approximate Interval Between Onset and Death
ician		Immediate Cause (Final disease or condition resulting in death)	a Respirati	on ta	ilme			2 WKS
lical iner		Tosularing in dealiny	a. Respirate Due to for as a consequence b. Multiple	juence of):)			1 month
*	e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	luence of):	oma			1 , , , ,
ansıı	Examlner	cause. Enter Underlying Cause (Disease or injury that initiated events	0	V				
riai-tr		resulting in death) Last	Due to (or as a conseq	juence of):				
the burial-transit	cal	•	d					
for use as th	Med	IF FEMALE:						
oc no	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnature 1 ☐ Live birth 2 ☐ Feta	al death 3 ☐Ectopic	pregnancy		23d. Date of del Month	ivery Day Year
	yslc	1 ☐ Yes 2 🕷 No 9 ☐ Unknown	4□Pregnant at time of c 9□Unknown	death 5 ☐ Other	(specify)			•
Oela		Part II. Other significant conditions of	contributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
should be detached	d by					1 ☐ Yes	2 X No 3 □ Pr	robably 4 Unknown
0	Completed					24a. Was an	24b. Were au	utopsy findings available
page z	шс					 autopsy performed 	prior to death?	completion of cause of
	a)	25. Was case referred to medical			26. Place of D	1 ☐ Yes 2 Death (Check only one)	No 1 ☐ Yes	2□ No
director,	O B	examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	Other	Home 5 Residence	e 6 □Other (Spe	cify)
funeral	T :uc	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how i		
the fur	atlo	2 Accident investigation	n	М	1 ☐ Yes 2 ☐ No			
in by t	Certification;	3 Suicide 6 Could not b 4 Homicide determined		ome, farm, street, factify)	ory, office	28f. Location (Stree City or Town, S		ural Route Number,
illedi	Cel	DOS CONTROL AND CONTROL OF	Nucleio- To the base of			1		
*	edical	29a. Certifier 1 Cartifying Pt (Check only 2 Medical Examone)	nysician: To the best of my kno ninar: On the basis of examina and manner stated.	ation and/or investigat	on, in my opinion, death oc	ccurred at the time, date	and place, and due	to the cause(s)
stely	Med	29b. Signature and title of certifier	and marrier stated.		29c. License number	29d.	Date signed (Mont.	h, Day, Year)
ompletely	_	- / /	1 0	^	7 0		11. 1.	
completely	-) mere	ZUP, IM	ry.	1)-1920	/	1/5/06	
completely	-	30. Name at address of person who	completed cause of death (Ital	m 23a) (Type, Print)	0-19250		1/5/08	,
Wittin 24 nous aner usan: To the Funeral Director: A completely filled in by the t		30. Name at address of person who JAE 5. CHWN 6.	A	m 23a) (Type, Print) Apolis Ri	D-19250 Suite 306	Lanham	, MD 2	0706

			1- For State of Marylar Registrar	•	artment of Heartificate of De			jiene	5 011.85
	/		1. Decedent's Name (First, Middle, Last)				2. Date of Dea	th	3. Time of Death
	Physici /Medio		William Alex Mattero				Month January		11:24 a M
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc	cation of Death		4c. County of	
1			Suburban Hospital		Bethesda	9		Mont	gomery
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year If		8. Date of Birth (Month, Day		D. Birthplace (State or Foreign Country)
	Director		219-13-4718 1	25 Yrs.	World's Days	10013	Nov. 8,		Maryland
	p ,		Usual Residence of Decedent 10a. State 10b. County 10c. C	iby Tours or La					
	anyla shov	-		ity, Town or Lo	cation				10d. Inside City Limits 1 XYes 2 No
	Ba-f	ctc	Maryland Montgomery	Kensi	7				
	ith th	Director	10e. Street and Number		10f. Zip Code			0g. Citizen of Wh	·
	ath w	<u>ra</u>	3712 Farragut Avenue		20895			USA	
	er de	by Funeral	11. Marital Status 12. Was Decedent Ever in the Armed Forces?	J.S. 13. V	Was Decedent of Hispa f Yes, specify Cuban, M	nic Origin? (Sp Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	American Indian, White, etc.
36	s afte	YF	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		1 ☐ Yes Ž No S	Specify:		Specify:W	hite
21215-0036	within 72 hours after death with the Maryland ene. than 'natural', or Itams 23a or 28a-f show tha Madical Examinat r. wat be motified at	be be	3 Widowed 4 Divorced Year or Dates:	16a Decer	dent's Usual Occupation			10h Kind of Busin	
15	n 72	Completed	(Specify only highest grade completed)	(Give	kind of work done during DO NOT use retired)	ng most of work	ing	16b. Kind of Busin	ness/industry
12	within ene.	mc.	Elementary/Secondary (0-12) College (1-4or 5+)		n Apprentic	۵.		Electri	cal.
	filled Hygi thar	ပိ	17. Father's Name (First, Middle, Last)	J GIIIIGI			e (First, Middle,	Maiden Sumame)	Cal
an	d be ental	To B	William Joseph Mattero			Andre 1	/ D	·	
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked othar than "traumatic svant, the Mass	1	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and		1. Bonie a/Route Numbe		ate, Zip Code)
Ma	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. item 27 Is marked other than "natural", or Itams 23e or 28e-f show item 27 Is marked other than "natural", or Itams 23e or 28e-f show other traumatic event, the Madical Examining 1. Mail be rediffied at		Anita M. Mattero/Mother		Farragut A				
ē,	Hea Hea tam		20a. Method of Disposition 20b.	Place of Dispo	sition (Name of	1	Date _	20c. Location - Ci	
no	80 = 5				matory or other place) morial Park	Janua 200	ry 8,	Rockvill	e, Maryland
Baltimore,			21. Signature of Funeral Service Licensee	22	. Name and Address of	f Facility.			
Ba	permit. Departr Importa any inju		L. Ken Stile	Fi	Name and Address of rancis J. C OO Universi	Collins ty Bluc	Funeral	Home In	c ing, MD 20901
	- E - 4	_	23a. Cant1. Enter the disease, or complications that caused the dea						Approximate
			shock, or heart failure. List only one cause on each line.		, 3.				Interval Between Onset and Death
	Physician /Medical		disease or condition a. Hulling in death)			·	_		
	Examiner		Due to (or as a consec						
	- '	e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	1a quence of):					
	t ansit	i E	cause. Enter Underlying Cause (Disease or injury that initiated events c.						
΄,	n and	Exa	resulting in death) Last C. Due to (or as a consec	quence of):					
8760,	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical Examiner	d						
9	ifficat g phy as th	ed							
Вох	teath certifica attending ph I for use as th	N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregn		T			23d. Date of	of delivery
	death e atte d for	cla	in the past 12 months? 1 Yes 2 No 4 Pregnant at time of the state of		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	that the death ned by the atter detached for u	hys	9 Unknown 9 Unknown						
	iw requires that s been signed b should be deta	by P	Part II. Other significant conditions contributing to death but not re-	sulting in the ur	nderlying cause given in	Part I.	23e. Did to	bacco use contribu	ute to the cause of death?
Records,	quire an sig	ed					1 🗆 Y	es 2 [™] No 3(☐ Probably 4 ☐Unknown
CO	law re	Completed					24a. Was a	n 24b. We	re autopsy findings available
R	The la	E O					autops perfor 1 \(\sum \) Yes	ned? dea	or to completion of cause of th? Yes 2 □ No
ta		e e	25. Was case referred to medical	-	26	. Place of Deat	Check only or		1163 2010
of Vital	S W D	To B	examiner? 1 X Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatien	Othor			ence 6 Other	(Specify)
	g Ph er th		27. Manner of Death 28a. Date of Injury 1 Natural 5 Pending (Month, Day Year)	28b. Time of Injury				ow injury occurred	
0	Attanding I r death. ector: After by the funer	atlo	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation Jan. 4, 200	5 10:45		2 💆 No	Jumped	off parki	ing garage
Division	I or Attanatite deat	Certification:	3∑ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At homicide 28e. Place of Injury - At homicide, etc. (Special Special S	iome, farm, str	eet, factory, office		28f. Location (S	reet and Number	or Rural Route Number, ner of Elm St.
Ö	tal or A s after al Direct	Cer	Ballating, c.s. (open		ng garage	ā			, Bethesda, MD
	To tha Hospital or Attanding Ph within 24 hours after death. To tha Funaral Director: After th completely filled in by the funeral		29a. Certifier (Check only (Check only 2X) Medical Examiner: On the basis of examin.	owledge, death	occurred at the time, d	date and place,	and due to the c	ause(s) and mann	er as stated.
	tha h in 24 tha F iplete	ledical	one) and manner stated.	acon and/or inv					
	To 1	Σ	29b. Signature and title of certifier	ma	29c. License nu		2	9d. Date signed (A	Month, Day, Year)
	1 %		Fatricia Tomsko May,	INDU	D519	16		Januar	ry 4, 2005
	10		30. Name and address of person who completed cause of death (He Patricia Tomsko-Nay, M.D. 11.		Print) kville Pik	e, Gl00	, Rockv	ille, MD	20852
£	Sta Regista		31. Date filed (Month, Day, Year) JAN 0 6 2005	ature Apr	de				

			For State Registrar	State of M	farylanc	d / Depa <i>Cei</i>	artment of H tificate of	lealth a	and Me	ental Hyg	giene Reg. No.	200	5	01486
	Physici	an	1. Decedent's Name (First, Middle, Last,						2	2. Date of Dea Month	Day	Yea	ar	3. Time of Death
5	/Medic	al	ANNA 4a. Facility Name (If not institution, give		MILLER		4b. City, Town, o	- 1 tion -	4 Danth	JANUAR	XY 2	2005 County of D		1:20 A M
	Examin	er	JEWISH CONVALESCE			Œ		IMORE			40.	BALTI		E
	Funeral		5. Social Security Number 6. Sec	x 7. A	Age (In yrs. Ia		If Under 1 Year Months Days			B. Date of Birti (Month, Day	h (Year)			ce (State or Foreign
	Director]M 27 F	87	Yrs.	Months Days	riours		IAN 22,	19	l7 WA	SHI	NGTON, DC
	ow ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation						10d	I. Inside City Limits
	Mary a-1 sh	tor	MARYLAND BALTIMO	RE	ВА	LTIMO	RE							1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What	Country	/?
	ath w		7920 SCOTTS LEVEL				212					CED ST		
36	2 should be illed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, it a Medical Exaction or items must be retilised at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	5?] No		Was Decedent of H f Yes, specify Cub 1 ☐ Yes 21 No	lispanic Ori an, Mexican Specify:	gin? (Spec 1, Puerto Ri	ify Yes or No- ican, etc.)		14. Race - A Black, W Specify:		e
9	72 hou	ted	15. Decedent's Edu (Specify only highest grad	cation		16a. Deced	dent's Usual Occup	ation	t of working		16b, Ki	nd of Busine		
2	ithin 7.96.	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT use retire	d)	t or working	,				
2	filed w Hygier other tl		12 17. Father's Name (First, Middle, Last)				NONE	18 Mothe	r's Namo /	First, Middle,	Maiden	NONE		
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lar)	2 should and Men Is marka		19a. Informant's Name/Relationship (Ty	rpe, Print)		19b. Mailir	ng Address (Street	and Numbe	er or Rural	Route Numbe	r, City o	Town, State	e, Zip C	ode)
	1 and Health am 27 ther to		INA WATSON, NIEC 20a. Method of Disposition	E	20b. Pla		DALRYMPLI sition (Name of	E ROAD), SUN	_		D 20 cation - City	689	Ctato
nor	Pages nent of I		1 Metrico di Disposition 1 Metrico di Disp	Removal from Stat	e ce	metery, cren	natory or other pla							
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic evonce.		21. Signature of Fune al Service Ligens		_ r1.		OLN CEMETANZANSKY							ARYLAND
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	Physician		23a. Part. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	ications that causine cause on each	line.		-	ng, such as	cardiac or	respiratory are	rest,		In O	pproximate Interval Between Onset and Death
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8760,	cate be executed physician and the burial-transit	dicai Exar	that initiated events resulting in death) Last	Due to (or a	is a consequ	ence of):								***************************************
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.O. Box	The law requires that the death certific tie has been signed by the attending p cage 2 should be detached for use as:	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	/			2	23d. Date of Month	de livery Da	ay Year
۵,	res that the igned by be detact	by Ph	Part II. Other significant conditions co	ntributing to death	but not resul	Iting in the u	nderlying cause giv	en in Part I.		23e. Did to	bacco u	se contribute	e lo the	cause of death?
ğ	w require been sig should b	ed t								1 □ Y	es 21	2No 3□	Probab	ly 4 □Unknown
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Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:			04			Check onl or	ne			
of	d is	. To	1 ☐ Yes 2 X No	' 1 ∐Inpa	tient 2 E	R/Outpatien 28b. Time of		4 MINU		5 🗌 Resid			pecify)	
on	Attending Physician: ar death. ector: After this certification by the funeral director.	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In (Month, E	ay Year)	Injury	Wor	k? Yes 2 □ I		d. D0301100 11	OW INJUI	Cocarred		
Division of		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of I building,	njury - At hor etc. (Specify)	me, farm, str	eet, factory, office		28	f. Location (S City or Tow	itreet and m. State	d Number or	Rural A	Route Number,
	To tha Hospital or within 24 hours afte To the Funaral Dii completely filled in	Medical (29a. Certifier 1	sician: To the bes ner: On the basis and manner:	of examinate	vledge, death on and/or inv	n occurred at the tir restigation, in my o	me, date an pinion, dea	d place, an th occurred	d due to the c	ause(s) date and	and manner place, and c	as state due to th	ed. e cause(s)
	withi To t	Σ	29b. Signature and title of certifier	/	11	Λ	29c. Licens	e number		2	29d. Dat	e signed (Mo	onth, Da	y, Year)
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			30. Name and address of person who co			ETGHT	S AVENUE.	ВАТ	TIMOR	RE, MAR	ΥΙ.ΔΝ	JD 21	215	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien $\geqslant 0.05$ 01487 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day JAMES EDWARD PRICE January 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EASTON HOSPITAL Memorial 1Albot If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. DEC 24 1 938 5. Social Security Number 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** MARYLAND Director 214-36-5959 66 Yrs. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or items 23e or 28a-f shov Exertiner must be notified at 1 ☐ Yes ※☐ No Director TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27942 WOODS ROAD 21601 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No WHITE þ Specify: 3 Widowed 4 Divorced Completed traumetic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 0 PARTS MANAGER TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental | ٩ OWEN S. PRICE GRACE S. BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l PAMELA M. PRICE/WIFE 27942 WOODS ROAD, EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Importent: If it any injury or o once. ō 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 1-11-2005 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Joseph m. Ostrouski C. F. S.P. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Panchata Car cinvua disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the attending physician and hed for use as the burial-transit resulting in death) Last Due to (or as a consequence of) The faw requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4 ☐ Pregnant at time of death 9 Unknown 9 Unknown ģ been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1□ Yes 22 No 1 ☐ Yes 2 ☐ No Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No this 28a. Date of Injury (Month, Day Year) After the 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Datersigned (Month, Day, Year) 03718 05 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29466 PINTAIL DR EASTON, MD 21601 DAVID SMITH M.D. 31. Date filed (Month, Day, Year) State

Registrar

			State of Maryland / Dep 1- State AmendItem 17 per informant G84Ce	artment of H	lealth a De ath	nd Mer		iene 005	01488
	Physici	an	1. Decedent's Name (First, Middle, Last) Mary Jean Potts			-	Date of Deat	3	3. Time of Death
)	/Medic Examin	4.0	4a. Facility Name (If not institution, give street and number) 30191 Cochise Court	4b. City, Town, or		Death	ilual y	4c. County of De	ath
N	Funeral	~	Social Security Number 6. Sex 7. Age (In yrs. last birthday)		If Under 2	4 Hrs 0	Date of Birth	St. Mary	irthologo (State or Foreign
Ĭ.	Director		235-14-5924 1 □ M XXF 84 Yrs. Usual Residence of Decedent	Months Days	Hours	Min. D	(Month, Day, ec. 2,	1920 We	St Virginia
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	r 28a-1	Directo	Maryland St. Mary's Mechanic 10e. Street and Number	SVILLE 10f. Zip Code			10	0g. Citizen of What	
	ath with		30191 Cochise Court		20659			USA	
36	should be filed within 72 hours after death with the Maryland of Mendal Hygiene. marked other than "naturel", or items 23c or 28a-f show matic avent, the Modical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Acmed Forces? 1 ☒ Yes 2 □ No WWII Yes, Give Year or Dates:	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☒ No		in? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race - Ar Black, WI Specify: W	
Baltimore, Maryland 21215-0036	n "natura n "natura Modical E	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv life.	edent's Usual Occupa e kind of work done o DO NOT use retired	ation furing most	of working		16b. Kind of Busines	ss/Industry
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land	be be be	To Be	17. Father's Name (First, Middle, Last) Griffin Walter Mary Giffin Walter Warple	ote	Augus		irst, Middle, N 1orenc	<i>Maiden Sumame)</i> e Nealon	
Mary	2 s ls	_		ling Address (Street a					
ore,			20a. Method of Disposition 20b. Place of Disposition completely, or	ematory or other place	e)	Date	2	20c. Location - City	or Town, State
<u>E</u>	permit. Pages Department of Important: If it any injury or o		'4 □Donation 5 □Other (Specify) Raids C.	rematory 22. Name and Addres	i	/13/0.		dgewater,	
 Ba	Depril			5160 Oxon					
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	/Medical Examiner		Due to (or as a consequence of):	Disease					
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O. Box	death e atter	Physician/I	23b. Was decedent pregnant in the past 12 months?	□Ectopic pregnancy □ Other (specify)		-		23d. Date of o	elivery Day Year
S,	requires that the reen signed by th hould be detache	Ď	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause give	en in Part I.			7.7	to the cause of death?
Vital Record	> 40 70	ompleted			γ [±]	_ [24a. Was ar	n 24b. Were	autopsy findings available
al Re	: The law cate has b page 2 si	Com					autopsy perform 1 Yes 2	ned? death	
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	Hosp 4 hou Funa ely fii	edical C	29a. Certifier (Check only one) XX Certifying Physician: To the best of my knowledge, deal can be compared to the best of my knowledge.	th occurred at the tim	ne, date and pinion, death	place, and occurred a	due to the ca	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
.	To the within 2 To tha complet	Me	29b. Signature and title of pertifier	29c. License				od. Date signed (Mo January 10	
			30. Name and address of person who completed cause of death (Item 23a) (Type	MOO55					, =000
	3		Jennifer/Schmidt, M.D. 2050 Wildewood 31. Date filed (Month, Day, Year) 32. Registrar's Signature	od Center	Calife 	ornia,	, MD. 20	7018	
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'		For State Registrar		С	ertificate of	Death		giene () () [Reg. No.	0140
Physician		L'Decedent's Name (First, Middle, L	ast)				2. Date of De.	ath Day Ye	3. Time of Death
/Medical Examiner		Vera Christine Ra a. Facility Name (If not institution, g			4b. City, Town,	or Location of Dea		y 15, 2005 4c. County of D	
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uneral	1		Sex 7. Age (In yrs. last birthda	Months Davs	r If Under 24 Hrs Hours Min	. (Month, Da	y, Year)	Birthplace (State or Fore Country)
irector	I	057-07-6333 Usual Residence of Decedent		93 Yrs.			June 6,	1911 Oh	io
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or 28a-f show be nutified at Director	2	Virginia Jeffers	on H	larpers I					1 🎇 Yes 2 🗌
2 H		10e. Street and Number			10f. Zip Code			10g. Citizen of What	t Country?
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To atic		Leo B. Sciubba					a Tedesc		
e m m		19a. Informant's Name/Relationship		4					te, Zip Code) 2542
m 27 ner tr	-	Ronald Rago, son							s Ferry, WV
i of i	2	20a. Method of Disposition 1 X Burial 2 □ Cremation 3	☐Removal from State	20b. Place of Dis	sposition (Name of crematory or other pla	ace)	Date	20c. Location - City	or Town, State West
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beaut to physicians as: Vera C. Rago

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Day **Physician** Yaar Helen H. Rudy January 6 2005 4:10 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Buckingham's Choice Health Care Center Adamstown Frederick If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplaca (State or Foreign Country) **Funeral** Days 1 □ M 2 K F Months 216-42-6273 88 March 19, 1916 Director Maryland Usual Residence of Decedent 72 hours aftar death with the Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits show 1 Yes 2 No Funeral Director Maryland Frederick Middletown 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6909 Burkittsville Road U.S.A. 21769 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Giva Baltimore, Maryland 21215-0020 1 ☐ Yes 2 🙀 No Specify: \$ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be 1 Departmant of Health and Mental I Important: If Item 27 is marked of Clyde C. Harshman Nellie Johnson 19a. tnformant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Gary C. Rudy/Son 6909 Burkittsville Road, Middletown, Maryland, 21769 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Date ▼Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Middletown Lutheran Cemetery 01/10/2005 Middletown, Maryland 21. Signatura of Funeral Service Licenses 22. Name and Address of Facility 106 East Church Street Millian Frederick, MD, 21701 Keeney and Basford P.A. Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Daath Physician Motestatiz Colon CA /Medical Immediate Cause (Final disaasa or condition rasulting in death) Examiner Examiner The law requires that the death cartificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 XNo 3 Probably 4 Unknown δ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed TLIYOS 2XNU 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To 1 ☐ Yes 2 1 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending invastigation 1 Yes 2 No 2 Accident or Attendation of the deat 6 ☐ Could not be detarmined 3 Suicide 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital
 24 hours 6
 Funerel 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to the cause(s) and manner stated. 29a. Cartifier Medical (Check only one) To the I within 2 29c. License number P=A BL6786 > 28 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certified 1-6-65 m () mo 005 8786 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T, Mersville Mead 3000-0 6 32/ Registrar's Signature 31. Data filed (Month Phy. 1947) 2005 State

DHMH 16 Rev 6/95

Registrar

Box 68760

Division of Vital Records, P.O.

			For State of Ma	ryland / Depa	artment of F		Mental Hy	/giene2 ()	05	01491
	Bloods		Decedent's Name (First, Middle, Last)		· · · · · ·		2. Date of D		Year	3. Time of Death
4	Physici /Medic		SAMUEL LEE ROSE				JAN		005	405 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	0	4b. City, Town, o	r Location of Dea	th	4c. County		
			UPPER CHESA PEAKE MEDICA		BEL If Under 1 Year	H Under 24 Hrs	S 0 Data -15	HARI		
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(In yrs. last birthday) 56 Yrs.	Months Days	Hours Min	8. Date of B (Month, D	15, 1948		lace (State or Foreign try)
			Usual Residence of Decedent				160.	13, 1340	vir	ginia
	Maryland I-f ehow		10a. State 10b. County	10c. City, Town or Lo	cation				1	Od. Inside City Limits
	h the Marylan r 28a-f ehow r notified at	cto	Maryland Harford		Abero	leen				1 ☐ Yes 2 No
	within 72 hours after death with the enes ene. than "natural", or Items 23a or 28a na Modical Examinat he noti	al Directo	10e. Street and Number 114 St. Matthew Court		10f. Zip Code 210	01		10g. Citizen of V USA	Vhat Coun	try?
	deat	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Specify Yes or N	o- 14. Rac	e - Americ	
200	or Ite	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ N	0	1 ☐ Yes 2121 No	Specify:	no moan, etc./		k, White, Bla	-
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- 1	n 72 "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo d)	orking	16b. Kind of Bu	siness/Ind	lustry
2121	filed within Hygiene. Ither than Int, Ine M	шс	Elementary/Secondary (0-12) College (1-4or 5	+)	curity G	_		US Gov	ærnm	ent
D	be filed Ital Hygi of other	BeC	17. Father's Name (First, Middle, Last)				me (First, Middle	e, Maiden Sumam	e)	
<u>lar</u>		To B	Samuel Rose			Mattie	Wither	spoon		
Maryland	2 6 6 7		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street					
			Johnnie L. Rose / wife		St. Matt	hew Cour		-		
) <u>e</u>	@ O		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	1	natory`or other plac		Date	20c. Location -		
altimore.	t. Partmen tant:	. 1	*4 Donation 5 Other (Specify)	Berkley			/11/05	Darli	ngtor	ı, MD
, Bal	permit. Page Department Important: If any injury o		21. Signature of Funeral Service Licensee	22	Name and Address Lisa Se	ss of Facility Cott Fun	eral Hor	ne. P.A.		
~			23a. Part1. Enter the disease, or complications that caused	the death. Do not ent					ice,	MD 21078 Approximate
			shock, or heart failure. List only one cause on each lin Immediate Cause (Final	e. /2 Û		4				Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death) a	consequence of:	mare	an	Α		-	-
	Examiner		a to	- Porto	. Condia	maland	Par de	Rose		
ا م	0.72 =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of):						
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876	hy:	dical	d							
× 6	certif Iding Ise at	/Me	IF FEMALE: 23c. If yes, outcome	of pregnancy				23d Dat	e of delive	n/
Вох	eath atter	clar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 4 Pregnant at		Ectopic pregnancy Other (specify)	′		Mor		Day Year
O.	at the de by the a	Physician/M	9 ☐ Unknown							
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ecords,	w require been sig	ted	ceculo panererous				1 🗆	Yes 2□No	3 Prob	ably 4 Unknown
၂၂	law reas be	ple	Hy pertension				24a. Wa		Vere autop	psy findings available appletion of cause of
7 ==		Completed	Renal Pailine				perf 1 ☐ Yes	ormed? d	eath?	2 X No
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	ding I h. After funer	lon	1 Month, Day	y 28b. Time of Year) Injury	Wor	yat k? Yes 2 □ No	28d. Describe	how injury occurr	90	
Division	Attending Physician: r death. ector: After this certific. by the funeral director.	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Inju	ry - At home, farm, str		163 2 110	28f. Location	(Street and Number	ar or Rumi	Route Number
いる	ipital or Al burs efter o leral Direc filled in by	Certification:	4 Homicide determined building, etc.	. (Specify)				wn, State)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
2	Hospital or Atten 24 hours efter deatl • Funeral Director: etely filled in by the		29a. Certifier 1 Certifying Physician: To the best of	of my knowledge, death	occurred at the tin	ne, date and plac	e, and due to the	cause(s) and ma	nner as sta	ated.
	To the Hos within 24 h To the Fur completely	edical	(Check only one) 2 Medical Examiner: On the basis of and manner sta	examination and/or in- ted.	vestigation, in my o	pinion, death occ	urred at the time	, date and place, a	ind due to	the cause(s)
	To the I within 2 To the I complet	Σ	29b. Signature and title of certifier.		29c. Licens	e number		29d. Date signed	(Month, L	Day, Year)
	1 ~		Pener J. Glala Mill.	E	LOUIN	d06		Amay 6.	2005	
,	100,10		30. Name and address a per who completed cau e of d	eath (Item 23a) (Type,	PUN HIAA	IRD AVE	= Anz	To Ud a	7/2	2
	Sta	to	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	מוציקוי ע	1145 144	DINFT	unua	1000	1 0 7
	Registr	-	JAN 1 0 2005	A 18	S. S. C.					

Easton

last birthday)

10c. City, Town or Location

Certificate of Death

Easton

Days

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

Min.

2. Date of Death

Jarnary

8. Date of Birth (Month, Day, Year) APR 14 1929

10

2005

4c. County of Death

USA

Specify:

Talbot

0616

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

Year

Month

1 Yes 2 No

9. Birthplace (State or Foreign

MARYLAND

WHITE

Month

28a-f show

Decedent's Name (First, Middle, Last)

Memorial

5. Social Security Number

215-20-2429

10a. State

Usual Residence of Decedent

SAMUEL NORRIS SAULSBURY

Hospital

1XM 2□ F

4a. Facility Name (If not institution, give street and number)

the must be notified at or Items 23e or death v filed within 72 hours after the Medical Evan natural l Hygiene. or other treumatic event, Pages 1 and 2 should be in ment of Health and Mental I ant: If item 27 is marked o permit. Page Department o Important: If any injury or once.

> Physician /Medical Examiner

attending physicien and tor use as the burial-transit The law requires that the death certificate be executed Box 68760 P.O. Records. certificate Division of Vital Hospitel or Attending Physicien: Atter thi funeral death. within 24 hours efter death To the Funerel Director:

Director EASTON TALBOT 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 8803 BLACK DOG ALLEY 21601 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) SAFETY EQUIPMENT MECHANIC 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) LORETTA ELLIOTT MILTON CAMPBELL SAULSBURY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8803 BLACK DOG ALLEY, EASTON, MARYLAND 21601 ANNA BELLA SAULSBURY/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State EASTON, MARYLAND SPRING HILL CEMETERY 1-14-2005 * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARKISON ST EASTON, MD 21601 21. Signature of Funeral Service Licensee Joseph M. Ostrowski C.f.S.R. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) obstruct eve Chronic Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did topacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ٢ 1 Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier oluprotses D0059487 10 30. Name an Inddress of person who completed cause of death (Item 23a) (Type, Print) 219 S WASHINGTON ST EASTON, MD 21601 JOHN BOTSIS M.D. JAN 1 2 2005 31. Date filed (Month Registrar

Samue

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Maryland 21215-0036

DHMH 17 Rev 1/2001

ORIGINAL

Clara Schlotzhauer

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			1 - For State Registrar		State	of Ma	ryland				lealth : D <i>eath</i>		lental Hy	/gien Reg. N	200	5	0149	3
	Physici	al	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day									3. Time of Death	М					
-	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death								9 4	2005 c. County of D	ath	7:40 P	<u>M</u> _			
	Funeral		5. Social Security N	umber 6. S	Sex			est birthday)	If Und	r 1 Year	ston If Under	24 Hrs.	8. Date of Bi	rth V	Talbot 9. Birthplace (State or Fore			ign
L	Director	Usual Residence of Decedent 1 M 2 M F 94 Yrs. Months Days Hours Min. MAY 8 1910 M									ARYI	AND						
	ahow ahow										10d	Inside City Limi						
	in the N or 28a-f e notifi	Director	MD 10e. Street and Nur	TALB	OT			EAS	TON 10f. Z	p Code		<u></u>		10g. C	itizen of What	Country		
	s 23a o			TCHMANS	Ţ -					216					USA			
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f ahow any injury or other traumatic event, the Nedical Examinat must be notified at ance.	by Funeral	11. Marital Status 1 □ Never Marri 3 ☑ Widowed	ed 2 Married	12. Was Dec Armed F 1 Tes If Yes, G Year or I	orces? 2X N ive			Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes X No <i>Specify:</i>					14. Race - American II Black, White, etc. Specify: WHITE				
<u>5</u>	"natur	eted	(Spec	15. Decedent's E		")		16a. Dece (Give	kind of w	ork done o	turina mos	st of work	ing	16b.	Kind of Busine			
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	and 2 lealth a m 27 is har trai			PETITT/D	AUGHTER	}	Tani Bi				UGH S				RYLAND			
more	Pages 1 nent of H int: If iter iry or oth			osition Cremation 3 5 Other (Specif		State	ce	ace of Dispo metery, cre PAUL	matory or	other plac	-		Date 7-2005		DRDOVA,			
Baltimore,	permit. Departm Importa any inju		21. Signature of Fu	neral Service Licer	nsee	C.F.S		FE	2. Name a	nd Addres	s of Facili	ty BEIN	& NEWN	I MA	FUNERAL			
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	Physician		Immediate Cause (disease or condition resulting in death)	Final	a. P	nea	mo	nia								Ö	terval Between nset and Death	
	/Medical Examiner			(Due to	(or as a	consequ	ence of):	N							1,,	mk	
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60,	be executed sician and burial-transit		that initiated events resulting in death) L				consequ		n	nsag	ficie	ncy				9	ezvs	-
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Вох	leath certificate t attending physi I for use as the b	an/Me	IF FEMALE: 23b. Was decedent		23c. If yes, or		of pregnan		7Ectonic :	pregnancy			the state of the s		23d. Date of	delivery		
o.	the dea y the att	by Physiclan/Medical	in the past 12 1 ☐ Yes 2 ☑ 9 ☐ Unknown			nant at t	ime of de		Other (s						Month	Da	y Year	
rds, P	w requires that the de been signed by the s should be detached t	ed by Pł	Part II. Dther signifi	icant conditions o	contributing to	death bu	t not resul	iting in the u	nderlying	cause give	en in Part I	•		tobacco Yes 2		to the o	ause of death?	vn
Records,	a 5.5	Completed											24a. Was auto perfo		prior t death	o compl ?	findings availabetion of cause o	le f
Viital	ician: sertifica ector, p	Be	25. Was case referrexaminer?	red to medical	Hospital:							of Death	(Check only		0 10:	55 21	140	
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Division of	tendin leath. tor: Aft the fun	catlo	1 Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending investigation 6 ☐ Could not b	1			Injury	М	101	res 2 🗆	No						
<u>×</u>	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	4 Homicide	determined	28e. Plac build	e of Injur ding, etc.	ry - At hor (Specify)	ne, farm, sti	eet, facto	y, office			28f. Location (City or To	Street a wn, Stat	nd Number or e)	Rural R	oute Number,	
	Hospit 24 hour Funera etely fills	Medical	29a. Certifier (Check only one)	1 Certifying Pl	niner: On the l	e best or basis of	examınatı	vledge, deat on and/or in	h occurred vestigatio	at the tim	e, date an pinion, dea	d place, ath occurr	and due to the ed at the time,	cause(s	s) and manner od place, and d	as state	d. e cause(s)	
	To the within To the compile	Me	29b. Signature and	title of certifier	1				29	c. License	number			29d. Da	ate signed (Mo	nth, Day	r, Year)	
•			20 Name and a 4	ma	קנוכים	no		00-) 7	D-i- ii		DV	5939	,		1.10.0	5		
			30. Name and addre	ROWL	C7 M	D OI DE	sth (Item)		LEW LEW	CUI	AVE	NUC	E	75T	on ma	0	21601	
	Sta Registr		31. Date filed (Mont	JAN 1 1	2005 32.1	Recorrai	r's Signatu	Jr.	free	8								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12, BEATRICE 2005 5:40 LOUISE Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Grace Havre de Harford 8. Date of Birth (Month, Day, 3/21/. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 219-22-3962 79 Director Tennessee Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov traumatic svent, the Mudical Examinar must be notified at 1 Yes 2 No Director MD. Harford Havre de Grace 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3603 Old Level Road 21078 or itema 23a United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married ☐ Yes 2 Yes, Give 1 ☐ Yes 2 No Specify: λq 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. filed within Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home othert 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) 1 and 2 should be fit Health and Mental H tem 27 is marked ott Be Jake C. Cooper Armeldi Jane Foust 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 903 if item 27 i Theresa Riley/Granddaughter 25 Richmond Drive Perryville, Md. other nore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1715 Pages 1 injury or Department of Important: If any injury or once. 2005 * 4 □ Donation 5 □ Other (Specify) Jarrettsville Cem. Jarrettsville, Md. 22. Name and Address of Facility Jarrettsville, Maryland 21. Signature of Funeral Service Ucensee E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that called t shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) OFSTMICHUE LUNG Physician 0 /Medical Due to (or as a consequence of): Examiner WEWIM P Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 \(\subsection \text{Yes} \quad 2 \subsection \text{No} \) 23d. Date of delivery 3 Ectopic pregnancy for Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner2 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 257 No Certification: To 1 Dinpatient 2 ER/Outpatient 3 DOA s after death.
I Director: After this of in by the funeral di 27. Mariner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred ivision 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 05 who completed cause of death (Item 23a) (Type, Print) Name and address 3 4. 44

DHMH 17 Rev 1/2001

State Registrar 31. Date filed

•		a FOI	artment of Health and Mental Hygiene rtificate of Death Reg. No. 2005 0 495
	K	Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
Physicia		Pauline Virginia Snurr	January 13,2005 5:51 A M
/Medica		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
Examine	er	Frederick Memorial Hospital	Frederick Frederick
Europol		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	
Funeral Director		202-20-1893 1□M 2XF 86 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. Aug. 31, 1918 9. Birthplace (State or Foreign Mary Land
		Usual Residence of Decedent	
ylan		10a. State 10b. County 10c. City, Town or L	
Ma Fired	io	Maryland Frederick Myersvi	.11e
th the	i e	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
23e	by Funeral Director	11011 Easterday Road	21773 USA
dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
afte or it	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🏋 No	1 ☐ Yes 2 🖾 No Specify: Specify: White
nours urai',	g p	3 X Widowed 4 □ Divorced Year or Dates:	while
1215-0036 with 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28a-f show the Medical Exam art must be invitified at	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	ident's Usual Occupation 16b. Kind of Business/Industry 5 kind of Work done during most of working DO NOT use retired)
Withir than	d L	Elementary/Secondary (0-12) College (1-4or 5+)	nemaker Own Home
d 21 filed will Hygien ther th	မ ပိ	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
aryland 2121. should be filed within and Mental Hygiene. s marked other than "umatic event. Its Mes	m I	Alvey Keiffer Houp	Eva Susan Green
should Ind Men of Marke	٥	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Maryland nd 2 should be file the and Mental Hy 27 is marked oth traumatic event			Rosebay Court, Frederick, Maryland 21703
Heall Heall Heall Heall Heall		20a Method of Disposition 20b. Place of Disp	osition (Name of Date 20c, Location - City or Town, State
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event. It is Wedley Exam national be conflicted at	6.44	1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Zion Turt	matory or other place) neran Cemt. 1-15-2005 Middletown, Maryland
Itin		4 Donation 5 Other (Specify)	2. Name and Address of Facility 504 Main Street
Bal Bermi Depar Import any ir			Locketts Funeral Home Myersville, MD 21773
	-	Jan & Grigolas	
		23a. Part1. Enter the disease of conflications that caused the death. Do not enshock, Y mart failure. List only one cause on each line.	\ Conset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	irt tailire Unknown
Examiner		Due to (or as —consequence of):	
	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
V.1. pg tg.	Examiner	Sequentially list conditions, if any, leading to immediate stude. Exter Underhiring Cause (Disease or Injury that initiated events c.	
xecu al-tra	xar	that initiated events c. resulting in death) Last Due to (or as a consequence of):	
bu bu	calE		
587 licate phys s the		d	
Box 68	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
BC eath eath for u	clar	in the past 12 mymths?	□Ectopic pregnancy Month Day Year
P.O. that the de ed by the detached	ıysı	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	
IS, P.(y P	Part II. Other significant conditions contributing to death but not resulting in the	anderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
ds sign	d by	i. Atrial Fibrillation	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Records,	Completed	a. Hyportension	24a. Was an 24b. Were autopsy findings available
The far	dm	t. Manager	autopsy prior to completion of cause of death?
Vital Recipion: The law sician: The law rector, page 2 s	CC	25. Was case referred to medical	1 Ves 2 No 1 Yes 2 No
f Vita ysician: is certific director,	00	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othor
on of ding Physics After this funeral dir	5. To	27. Manger of Death 28a. Date of Injury 28b. Time of	
On ding th. Afte	tio	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 □ Yes 2 □ No
Division of Vital I or Attending Physician: 1 after death. Director: After this certifical I in by the funeral director, p	Certification:	3 Suicide 6 Could not be	reet, factory, office 28f. Location (Street and Number or Rural Route Number,
Dispersion of the dispersion o	ert	4 Homicide determined building, etc. (Specify)	City or Town, State)
spita nours neral			th occurred at the time, date and place, and due to the cause(s) and manner as stated.
Divisio To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical		ovestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
Withir To th	ž	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
		> Clyman M.D.	00055793 /-13-05
		30. Name and address of person who completed cause of death (Item 23a) (Type	
H		Suresh K. Manon M.D.	- Frederick Memorial Hospital
Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	
Registra	ır	JAN 2 1 2005 Blown &	neels)

			1 - For State Registrar	State of Man		partment of Fertificate of			gienę Reg. No.		01496		
•	Physici /Medic		Decedent's Name (First, Middle, Last, ALFRED J		ER			2. Date of Dea Month JANUARY	Day	2005	3. Time of Death 5:38A		
	Examin		4a. Facility Name (If not institution, give 5220 TRAILWAY DR			4b. City, Town, o	r Location of Dea LE	th	4c. County of Deeth MONTGOMERY				
	Funeral Director		0,700,750	7. Age (I	n yrs. last birthda 64 Yrs.	Months Days	If Under 24 Hr Hours Mir			9. Birth Cou	place (State or Foreign intry) ECTICUT		
	iand ow		Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or	Location					10d. Inside City Limits		
	e Man	ctor	MARYLAND MONTGOM	ERY	ROCKV	LLE					1 X Yes 2 □ No		
	with the	Directo	10e. Street and Number			10f. Zip Code				zen of What Cou	•		
	heath v	Funeral	5220 TRAILWAY DR	IVE 12. Was Decedent Eve	or in U.S. 13	. Was Decedent of H	20853	Specify Yes or No-		14. Race - Amer			
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Mapartment: If tiern 27 is marked other than "naturel", or items 23a or 28a-f show any injury of other traumatic event, the Medical Exercises must be notified a angle. Once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cub. 1 ☐ Yes 2 🛣 No	specify:	rto Rican, etc.)	1	Black, White Specify:	, etc. WHITE		
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7	within ene. than '	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire		ECIALIST	FE	EDERAL G	OVERNMENT		
2	ould be filed with the miles of the miles with the miles of the the file ovent, the miles of the	Be Co	17. Father's Name (First, Middle, Last)	5+			18. Mother's Na	ım <i>e (First, Middle,</i>	Maiden .	Sumame)			
yland	should be nd Mental marked c	To B	SAMUEL SILLER				MINNA	A MARTER					
	12 sho h and 7 is m traum		19a. Informant's Name/Relationship (T)			iling Address (Street							
5 -	Health Health tem 27 other tr		ARLENE B. SILLER 20a Method of Disposition		20b. Place of Dis	TRAILWAY cosition (Name of ematory or other place)		Date		cation - City or T			
Ē	Pages nent of ant: # it		1 🖾 Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	temoval from State		ANON CEMET		/05/2005	ΑD	ELPHI.	MARYLAND		
Dairimor	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licens	Stottlen		22. Name and Addre	ss of Facility						
	Physician /Medical Examiner		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)		CIC ADEN	nter the mode of dyir					Approximate Interval Between Onset and Death		
,0070	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of):										
DOX O	death certif e attending id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		23d. Date of delivery Month Day								
ר , אם	uires that n signed b Id be deta	b	Part II. Other significant conditions con	ntnbuting to death but n	ot resulting in the	underlying cause giv	en in Part I.	23e. Did to			the cause of death?		
	The la ate has page 2	Completed						24a. Was a autop perfor	sy med? 2 2 No	24b. Were aut prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of		
Vital	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 XYes 2 No	lospital:	2 ER/Outpati	ent 3 DOA Oth		eath (Check only or Home 5 A Resid		□Other (Snec	(6/)		
ald this		-	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye		of 28c. Injur		28d. Describe h					
=	i gite o	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, s Specify)	street, factory, office		28f. Location (S City or Tow	itreet and n, State)	l Number or Rur	al Route Number,		
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of mer: On the basis of ex and manner stated	amination and/or	ath occurred at the tir investigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time, d	ause(s)	and manner as splace, and due to	stated. to the cause(s)		
	To the comp	Σ	29b. Signature and title of certifier)	MS	29c. Licens				signed (Month,	_		
	5		37 80	majored assets of the	h (ltom 02=) ~		5635		JANU	JARY 4,	2005		
			JOSEPH KAPLAN, MD			PHILIP DI	RIVE, SU	ITE 327,	OLNE	EY, MD 2	0832		
	Sta Registr		31. Date filed (Month, Pay, Year) JAN 0 6 20	32. egistrar's	Signature	parte							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNpend Item#23a.27.perME.G640.2717/05 TT

		UNPERM ITEM 1- State Registrar		arylan				ealth an Death		Reg	ene ₂ 0	05	014
Physici /Medi Examir	cal ner	Dorothy 4a. Facility Name (If not institution, give 6344 SPRINGWATER I	Jean Sestreet and number)		ns	,	Town, or	Location of C	JA		Day 15, 20 4c. County FREDER		3. Time of De. 9:12a
Funeral Director		2/8-34-04/2	9x 7. Ag □ M 2 🗗 F	je (In yrs. Ia 51	ast birthday) Yrs.	If Unde Months	Days	If Under 24 Hours	Hrs. 8. D	Pate of Birth Month, Day, Y an. 27,	T953	9. Birth	place (State or Fo ntry))
Sa-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Frederi	ck			. Town or Location ederick							10d. Inside City L 1 ☐ Yes 2
3a or 28	Funeral Director	10e. Street and Number 6344 Springwater	Place #1	132			1701			10g	g. Citizen of V USA		ntry?
s 1 and 2 should be filed within 72 hours after death with the Maryland of Heatth and Mental Hygiene. It marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Evantral must be notified at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No			Was Dece f Yes, spe I Yes	cify Cuba	spanic Origin n, Mexican, F Specify:	n? (Specify Puerto Ricar	Yes or No- n, etc.)		k, White,	can Indian, , etc. Vhite
Hygiene. other than "natur ent, the Medical	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12	lucation de completed) College (1-4or	(Give life. l	Sa. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired) Salesperson				working		nd of Business/Industry		
and Mental Hygi Is marked other reumatic event, I	To Be C	17. Father's Name (First, Middle, Last) Lewis		ailey					Name <i>(Fir</i> e1ma	st, Middl e , Ma	iden Sumam Co11		· · · · ·
Health and Milem 27 Is mai		19a. Informant's Name/Relationship (1	Type, Print)							ute Number, C L ry, MD			p Code)
ent of He nt: If Item y or oth		20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Cé	ace of Dispo emetery, crem thaver	natory or	other plac		Date / 20 / 20		c. Location -		
Department of Heal Important: If Item 2 any injury or other once.	1	21. Signature Pereral Service Licen		Kes	22	. Name a	nd Addres	s of Facility	Stauf	fer Fu	neral	lome ,	, PA
ysician Medical saminer	ler	23a. Part1 Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Athero: Due to (or as	scler	otic C								Approximate Interval Betwee Onset and Dea
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ed by the attending pt detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. if yes, outcome 1 Live birth 4 Pregnant a	2 Fetal	death 3	Ectopic p Other (s	regnancy oecify)				23d. Dat Mor	e of deliv	ery Day Year
sign d be	þ	Part II. Other significant conditions c	ontributing to death b	out not resu	itting in the ur	nderlying	cause give	en in Part I.	_ :				he cause of death bably 4 □Unkr
has Je 2	Completed								-	24a. Was an autopsy performe Yes 2	d? P		opsy findings avai empletion of cause 2 No
is certificate director, pag	To Be	25. Was case referred to medical examiner? Yes 2 \[\] No	Hospital: 1 Inpati	ent 2 🗆 I	ER/Outpatien	t 3 D	OA Othe	200		eck only one) 5 ☐ Residend	ce ¥ ₹ 7 Othe	er (Speci	^{fy)} SCENE
ir death. ector: After this certific by the funeral director.	ertification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	ime of 28c. Injury at				28d. Describe how injury occurred		ed		
i Dir	0	4 Homicide determined	building, et	ic."(Specify	")					City or Town, S	State)		al Route Number,
Fur ely	edical	29a. Certifier 1☐ Certifying Ph (Check only one) 1☐ Certifying Ph	ysician: To the best niner: On the basis o and manner st	of examinat	wledge, death ion and/or inv	occurred estigation	at the tin	ne, date and pointion, death	place, and o occurred at	the time, date	se(s) and ma and place, a	nner as s and due t	stated. o the cause(s)
within 2. To the I complet	Me	29b. Signature and title of certifiling	nyll			29	c. License	o number OCME			. Date signed ANUARY		
		30. Name and address of person who	completed cause of o		111	-	STRE	ET, BA	LTIMO	RE,MAR	YLAND	2120	1
St. Regist	ate rar	31. Date filed (Month, PAN ear) 8	2005 32. Pagiet	rar's Signat	ture	200							

		1 - For State Registrar	State o	f Maryland	d / Dep <i>Ce</i>	artmen rtificat	t of He e <i>of D</i>	alth and <i>eath</i>	Mental Hy	giene Reg. No		0149	
hysicia /Medic		1. Decedent's Name (First, Middle Clyde R Toms							2. Date of De Janua		16 2°65	3. Time of Death 7:00 P	
xamin		4a. Facility Name (If not institution, Frederick Me	morial H	Hospita		Fr	eder				. County of Deal rederi		
neral ector		219-20-1873	6. Sex 1.XXXII 2□ F	7. Age (In yrs. Ia 79	est birthday, Yrs.	If Under Months		f Under 24 Hrs Hours Mir		th , 192	9. Bird 2.5 Ma	thplace (State or Fore punity) aryland	
a-r snow	ctor	Usual Residence of Decedent 10a. State 10b. County Md • Fre	derick	10c. City	, Town or L	ocation nithsh	ourg	-14		10d. Inside City Lim			
230 or zo	al Director	10e. Street and Number 13913 Ridenour Rd. 21783									izen of What Co U.S.		
rai, or items 23e or 28a-t show Exammet must be colding at	by Funeral	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Fo	2 1 No	Was Deced If Yes, spec	ify Cuban,	anic Origin? (Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	p-	14. Race - Ame Black, Whit Specify:			
natu	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		-4or 5+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us Fami	Il Occupation done dur se retired)	on ing most of wo	orking	16b. K	ind of Business Far	•	
is markad other than sumatic event, the Mi	To Be Co	17. Father's Name (First, Middle, I Henry C. To					18		me (First, Middle Velma R.				
Z/ IS IN		19a. Informant's Name/Relationsh Deanna R. Willa		ter)		-			Bural Route Numb	-		Zip Code)	
Importent: If Item 27 Is marked any Injury or other treumatic er once.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (Sp.		State Mt.	ace of Dispo metery, gre Bethe	osition (Name matory or o e1 Cen	ne of ther place) netery	Jan 200	Date 20,		ocation - City or		
any Inju		21. Signature of Funeral Service L	Licensee	wis Mo		2. Name an			12 Home Sm		Bradbur burg,Md		
ician dical niner	4	23a Part Fith disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. SM	ach line.	OWE			Such as cardia		rrest,		Approximate Interval Between Onset and Death DAY	
the bur	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c. Due to (or as a consequence of): d.											
for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									23d. Date of delivery Month Day Ye		
should be detached	þ	Part II. Other significant continuous contributing to death but not resoluting in the underlying cause given in Part I.										contribute to the cause of death?	
page 2	Completed								24a. Was autor perio 1 \(\text{Yes}		24b. Were au prior to death? 1 □ Yes	topsy findings availated to the completion of cause of the cause of th	
ے د	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	npatient 2 E	R/Outpatier	nt 3 D0	Other		eath <i>(Ch</i> eck only o		R □Othor (Spar	264	
e funeral di	 	27. Manner of Death 1 Natural 5 Pending 2 Accident investig.	28a. Date of	-	28b. Time o Injury		Bc. Injury at Work?		28d. Describe			ary)	
completely filled in by the funeral	Certification:	3 Suicide 6 Could n 4 Homicide determine	ned 288. Place	of Injury - At honing, etc. (Specify)		reet, factory	, office		28f. Location (3 City or Tox	Street and wn, State,	d Number or Ru)	ral Route Number,	
pletely fill	edical	29a. Certifier (Check only one) Certifying Certifying Certifying	Physicien: To the exeminer: On the ba and mann	sis of examination	riedge, deat on and/or in	h occurred a vestigation,	at the time, in my opini	date and plac on, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
com	×	29b. Signature and title of certifier	Re H	atique	+45		License n				e signed (Month	n. Day, Year) 16, 2005 L, MD 2176	
-	ı F	30. Name and address of person v	vho ampleted caus	e of death (Item	23a) (Tyne	Print)							

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

				State of Mary				_					
			1 - For State Registra/MEND#5perINF1/			tificate of l			N2005	01499			
			Decedent's Name (First, Middle, Last)			~~~		2. Date of Death Month	Day Year	3. Time of Death			
	Physicia /Medic		Priscilla Vince					Jan. 3,	2005	8:30 P M			
^	Examin	er	4a. Facility Name (If not institution, give s			**	Location of Death		4c. County of Dea				
			4978 Sentinel Dr. 5. Social Security Number 6. Sex		yrs. last birthday)	Bethesda If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Montgome 9. Bi				
	Funeral Director			M 2⊠F	84 _{Yrs.}	Months Days	Hours Min.	8. Date of Birth (Month, Day,) Jul. 17,]	920 Ne	nthplace (State or Foreign ountry) Jersey			
	yland how		10a. State 10b. County	_	c. City, Town or Lo	cation			10d. Inside City Limits				
	Ba-f e	cto	MD Montgome	ry B	Sethesda					Þr Yes 2 No			
	vith th	Dire	10e. Street and Number	#206		10f. Zip Code		109	g. Citizen of What C USA	ountry?			
	eath v	eral	4978 Sentinel Driv	12. Was Decedent Ever	in U.S. 13. V	20816		ecify Yes or No-	14. Race - Am				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28a-f show any igury or other treumatic event, the Medical Exart at right to Indifficat at any igury or other treumatic event, the Medical Exart at right to Indifficat at agree.	by Funeral Director	1 □ Never Married 2 □ Married 3 🎖 Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		f Yes, specify Cuba '∐ Yes 2. X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)	Black, Wh				
9	2 hou	ted	15. Decedent's Educ		16a. Deced	lent's Usual Occupa	ation during most of work	ing 16	6b. Kind of Business	s/Industry			
215	thin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired	d)		* • • •				
21	led wi lygien her th	Con	A. T. T. Salanda Nama (Cinet Mindella Land)	5+	Nurs	e	19 Mothor's Nam	e (First, Middle, Ma	Hospital				
Baltimore, Maryland 21215-0036	uld be fi Mental H arked otl	To Be	17. Father's Name (First, Middle, Last) Clinton S. Ward				Elean	or Rabey					
lan	2 sho		19a. Informant's Name/Relationship (Type		0.000 1721				City or Town, State,	Zip Code)			
e, l	1 and Health em 27 ther t		Clinton Vince / So 20a. Method of Disposition	n 2	0b. Place of Dispos cemetery, cren	Overlool sition (Name of	k Rd. N.W		20016 lc. Location - City or	Town, State			
nor	ages nt of nt t: # it		1 Burial 2 □ Cremation 3 □ R ' 4 □ Donation = 5 □ Other (Specify)	emoval from State	cemetery, cren Parklawn				Rockville				
ij	artme orten injur			21. Signature of Funeral Service Licensee 22. Name and Address of FacilityJoseph Gawler's Sons In									
ä	permi Depar Impor any ir		Villais K.	Bugge			nsin Ave	-					
7	·		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final				g, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death			
	Pnysician /Medical		disease or condition resulting in death)	Respirato Due to (or as a co		Le							
н	Examiner		Sequentially list conditions	Copd						years			
	sit sd	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a co		S ANY E IS							
_	and and II-tran	Examiner	that initiated events resulting in death) Last	Rheumatic Due to (or as a coi		sease				years			
760,	tte be executed tysician and he burial-transit	calE	L,	d									
687	ificate g phys as the								- Leven by the				
ŏ	death certificat e attending phy ed for use as the	an/M	23b. was decedent pregnant	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐		Ectopic pregnancy	ı		23d. Date of de	,			
.O.	0 0 0	by Physician/Medi	in the past 12 months? 1 □ Yes 2 █ No 9 □ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown		Other (specify)			Month	Day Year			
P.	that the de led by the a detached f	Phy	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?			
ds,	og De							1 ☐ Yes	2 ½ No 3 □ P	robably 4 Unknown			
ecords	> 11 0	Completed						24a. Was an		utopsy findings available			
α	9 4	omp						autopsy performe	d? death?	completion of cause of			
Vital	icien: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only one)	X				
of V	Physicien: this certific ral director,	ToE	1 Yes 2 No		2 ER/Outpatien		4 Nursing Ho		ce 6 □Other (Spe	ecify)			
o uc		lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	28c. Injun Worl	yat k? Yes 2 □ No	28d. Describe how	injury occurred				
Division	Attending r death. ector: After oy the fune	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm, stre		.63 2		et and Number or F	ural Route Number,			
<u>≥</u>	after Dire	Certification:	4 Homicide determined	building, etc. (S)		,		City or Town,	State)				
	To the Hospitel or Attendwithin 24 hours after death To the Funerel Director:	edical C		sician: To the best of my ner: On the basis of exa and manner stated.									
	To the h within 24 To the f complete	Me	29b. Signature and title o certifier			29c. License	e number	290	l. Date signed (Mon	th, Day, Year)			
	7) CM			D3347	4	Ja	nuary 4,	2005			
	8 7	/	30. Name and address of person who co						5900				
			David Hansen, M.D.	. 3301 Net	w Mexico	Ave. N.W	. #347, W	DC 2001	6				
	Sta Registi		31. Date filed (Month, Day, Year) JAN 0 6 20	32. Agistrar's S	Signature A	nove !							

State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** esleu 2005 na 1 C /Medical acility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner stertown 8. Date of Birth (Month, Day, Year) 110 If Under 24 Hrs. If Under Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. lest birthday) **Funeral** Days 1√12M 2□ F Months Hours 53 Director 196-36-8497 PA Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 1 No 2 No Worton Completed by Funeral Director MD Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21678 USA 11533 Stillpond Rd 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ XMarried 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Special Police Office State Employee 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Elizabeth Dobson James Lee Wesley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Linda Wesley (Wife) 11533 Still Pond Rd Worton, MD 21678 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fountain Cemetery 1/15/05 Big Woods, 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Bennie Smith FH-Worton, MD 21678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) **Medical** ANOXIC ENCEPHALORATAY Examiner Due to (or as a consequence of) Physician/Medical Examiner ours after death.

eerst Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the bunal-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) 3 days FASCITIS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown RENAC DISEASE 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Be Completed 1□Yes 🔊 No 1 Vist 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes ₹ No DS Inpatient 2 ☐ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28e. Date of Injury (Month, Dey Year) 27. Manger of Death 28b. Time of 28d. Describe how injury occurred 1 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) end manner stated To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 2005 30. Neme end address of person who completed cause of death (Item 23e) (Type, Print) Chestertown md. 21620 24. 223 High Se

Registrar DHMH 16 Rav 6/95

State

31. Date filed (Month, Day, Year)

JAN 1 1

32. Registrar's Signature

2005

Division of Vital Records, P.O. Box 68760.